DOCUMENT RESUME

ED 450 296 CG 030 651

TITLE	Improving Substance Abuse Treatment: The National Treatment Plan Initiative. Changing the Conversation.
INSTITUTION	Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Substance Abuse Treatment.
REPORT NO	SMA-00-3480
PUB DATE	2000-11-00
NOTE	308p.
AVAILABLE FROM	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. Web site: http://www.samhsa.gov.
PUB TYPE	Information Analyses (070)
EDRS PRICE	MF01/PC13 Plus Postage.
DESCRIPTORS	*Certification; *Counselor Training; *Drug Education; *Labor Force; Outcomes of Treatment; *Professional Training; *Substance Abuse

ABSTRACT

This report is the result of five expert panels and six regional public hearings around the country that focused on key persistent issues that have characterized discussions of substance abuse over the years: closing the treatment gap; reducing stigma and changing attitudes; improving and strengthening treatment systems; connecting services and research; and addressing workforce issues. Of particular interest is the Report of Panel V: Addressing Workforce Issues. Panel V identified three types of current workforce issues: education and training; credentialing; and supply, demand, and distribution. The objective of professionals to guarantee universal delivery of optimum standards of care, together with the recent connection between provider reimbursement and education levels, calls for a formal strategy and defines standards for educating and training substance abuse staff. The field also needs a cohesive and unified approach to counseling. Anecdotal evidence of staff shortages exists. The recommendations offered for alleviating these problems fall into three categories: those that address the need for a Federal agency, with responsibility for workforce-related issues such as education and development; those that seek to strengthen the workforce infrastructure in the substance abuse treatment system; and those that require implementation at a field and/or program level. (MKA)

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IMPROVING SUBSTANCE ABUSE TREATMENT: THE NATIONAL TREATMENT PLAN INITIATIVE

Changing the **Conversation**

NOVEMBER 2000

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Improving Substance Abuse Treatment: The National Treatment Plan Initiative

Changing the Conversation

NOVEMBER 2000

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Acknowledgements

The National Treatment Plan (NTP) Initiative is conducted under the general auspices of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and the CSAT National Advisory Council. At its meeting on May 12, 2000, the National Advisory Council formally recommended "*Changing the Conversation, Improving Substance Abuse Treatment: The National Treatment Plan Initiative*," to CSAT for its consideration and implementation as appropriate.

NTP reports are developed under the supervision of Dr. H. Westley Clark, Director; Dr. Camille T. Barry, Deputy Director; Donna M. Cotter, NTP Coordinator; and Dr. Mady Chalk, Director, Office of Managed Care. This report is based on the detailed review and recommendations of five expert panels that were convened by CSAT, and that deliberated from April 1999 through February 2000, with assistance from numerous CSAT staff. Representatives of the five panels and a steering group of field leaders formed an editorial review board for the report. The Lewin Group, led by Leslie J. Scallet, Project Director, and Dianne S. Faup, Project Manager, provided staff support to CSAT and to the panels.

The opinions expressed herein are the views of the panel members and do not necessarily reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS).

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Preface

> *The National Treatment Plan Initiative envisions a society in which people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated. We envision a society in which substance abuse and dependence is recognized as a public health issue, a treatable illness for which individuals deserve treatment. We envision a society in which high-quality services for alcohol and drug problems are widely available and where treatment is recognized as a specialized field of expertise.*

The Center for Substance Abuse Treatment (CSAT) began the National Treatment Plan Initiative (NTP) in the fall of 1998, to provide an opportunity for the field to reach a working consensus on how best to improve substance abuse treatment, and then to pursue action to effect needed change. The NTP is not designed to create a traditional "national plan" to be published and cited. Rather, it is intended to provide a common starting point, to engage people throughout the field in a collaborative effort, and to recommend the types of guidelines and actions that over time can lead to the goal of making effective substance abuse treatment available to all who need it.

Changing the Conversation is the first product of the NTP Initiative. It was developed through extensive examination of relevant research and past reports, consultation and discussion among experts reflecting a broad cross-section of opinion and experience throughout the field, and active solicitation of public comment. Expert panels met between April 1999 and February 2000. CSAT encouraged public comment through field publications and a dedicated web site, and convened public hearings from June through November 1999 to ensure that community perspectives were incorporated.

This volume, *Changing the Conversation: The National Treatment Plan Initiative to Improve Substance Abuse Treatment*, presents a set of guidelines and recommendations drawn from the work of the panels and the many additional individuals who participated in the hearings and submitted comments. It represents the collective vision of the participants in the NTP over the past eighteen months. A companion volume, *Changing the Conversation: Panel Reports, Public Hearings, and Participants*, contains the full panel reports, summaries of the public hearings, and lists of all contributors.

The Substance Abuse and Mental Health Services Administration (SAMHSA), CSAT, and the participants regard this as the beginning of a long-term effort that will engage the attention and energy of people throughout the country. CSAT has already undertaken a series of steps to implement the recommendations. As the initiative continues, the guidelines and recommendations will be reviewed periodically to assess what has been accomplished and respond to new ideas and changing circumstances. SAMHSA and CSAT hope that individuals and groups will join in the conversation, add to these guidelines and recommendations, adapt them to the needs of different States and communities, and use them to support action to improve treatment for substance abuse and dependence.

Foreword

The 1970 passage of the Hughes Act marked the beginning of concerted Federal efforts to solve the problem of substance abuse. Senator Harold Hughes of Iowa was a leading advocate for treatment and research of alcohol abuse and alcoholism, exemplifying the leadership of people in recovery. This investment has produced a great deal of progress. Research has shown that these illnesses have complex biological, psychological, and social causes and effects, that the brain itself changes after exposure to alcohol and drugs, and that these changes can last even after substance use ceases. Clinicians and practitioners now have effective treatment interventions that have helped countless individuals improve their health and lead productive lives.

In 1992, Congress created the Center for Substance Abuse Treatment (CSAT), within the Substance Abuse and Mental Health Services Administration (SAMHSA), to make more effective treatment and recovery services for alcohol and drug problems widely available to all Americans who need them. The National Treatment Plan Initiative (NTP) contributes to that mission.

CSAT plays a major role in translating advances in research — led by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) — into practice. The Office of National Drug Control Policy (ONDCP) establishes the *National Drug Control Strategy*, the overall Federal plan to combat illegal drugs. The strategy is comprised of a series of goals and objectives of which CSAT has primary responsibility for those related to treatment. These objectives include reducing by half the number of chronic drug users, the demand for illegal drugs, and the prevalence of drug use in the workplace and among youth by the year 2007. The ONDCP Director calls treatment "critical to attaining these targets, and the CSAT planning process ... essential to the provision of effective treatment."

Most important, the purpose of the NTP is to stimulate action, by CSAT and by the many others involved in the treatment of substance abuse and dependence. The NTP seeks to define a critical path toward CSAT's goal to ensure appropriate treatment for all who need it.

The NTP exemplifies the collaboration essential to achieving this ambitious goal. The CSAT National Advisory Council, the NTP steering group of leaders in the treatment field, as well as five expert panels have contributed their best advice and thinking to this document. CSAT sponsored six well-attended public hearings around the country and solicited additional views and information through mail, telephone, and the Internet. We extend our gratitude to and express our admiration for the many participants, from the field and from CSAT and SAMHSA, who have given so generously of their time, expertise, experience, and ideas to make this report possible. In particular, we thank the hundreds of individuals who came forward to testify so movingly at the public hearings.

CSAT and SAMHSA are committed to do their part. We are already examining our programs to see where we can incorporate these ideas, and are using them to develop agency budget proposals. We will regularly re-examine the guidelines and recommendations, as well as progress in implementing them. Some NTP recommendations lie within our current authority and program roles. For others, we can act as stewards — providing expertise, ideas, and resources to support activities, and convening interested Federal agencies or groups. Still others will require changes in law or public priorities that will have to be considered in the proper forum. Some areas lie beyond the purview of a Federal agency.

Ultimately, the success of the NTP Initiative depends on the commitment and action of a network of partners: providers; researchers; practitioners; the justice, social services, health and mental health communities; groups concerned with women, aging, children and families, HIV/AIDS, disabilities, homelessness, and the rich diversity of racial and ethnic populations; the faith community; Federal, State and local agencies and officials; tribal councils; and especially people with a history of substance abuse and dependence problems and their families and friends.

On behalf of SAMHSA, CSAT and the National Advisory Council on Substance Abuse Treatment, we invite all who share an interest in recovery from substance abuse and dependence to join us to continue the conversation and to tackle the challenges ahead.

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Changing the **Conversation**

THE NATIONAL TREATMENT PLAN INITIATIVE

Executive Summary

The problem of substance abuse and dependence has long troubled the Nation, requiring balance among concerns for public safety, moral values, and health. Advances in science have reshaped our understanding of addiction and created an array of effective behavioral and pharmacological interventions. The Center for Substance Abuse Treatment (CSAT) began the National Treatment Plan Initiative (NTP) to build on recent advances in the field, bring together the best ideas about improving treatment, and identify actions that could translate knowledge into practice.

- Between 13 million and 16 million people need treatment for alcoholism and/or drugs in any given year, but only 3 million receive care (SAMHSA, 1999; Institute of Medicine (IOM), 1997).
- Estimated annual spending for substance abuse prevention and treatment in 1997 was $11.9 billion. Of this amount, public spending accounted for $7.3 billion or nearly two-thirds, compared to just over half in 1986 (Coffey; Mark; King; Harwood; McKusick; Dilonardo; Buck; 2000).

An extensive body of federally funded research shows that, with treatment, primary drug use decreases by nearly half. In addition, reported alcohol and drug-related medical visits decline by more than 50 percent, criminal activity decreases by as much as 80 percent, and financial self-sufficiency improves (e.g., employment increases, and welfare receipt and homelessness decline) (SAMSHA, National Treatment Improvement Evaluation Study (NTIES), 1999). The NTP responds to these facts and to a range of other plans and initiatives on substance abuse and health. These include the goals for better treatment established by the Office of National Drug Control Policy (ONDCP) in the *National Drug Control Strategy* and the national health goals and objectives established by the Department of Health and Human Services (DHHS) in *Healthy People 2010.*

Five expert panels, representing a diversity of knowledge, experience, and views, considered previous reports and recommendations, then focused on what should be done next. CSAT sponsored a series of six regional public hearings around the country, and provided many additional avenues for public comment. Both the panels and the hearings were designed to focus on key persistent issues that have characterized discussions of substance abuse treatment over the years:

- Panel I: Closing the Treatment Gap
- Panel II: Reducing Stigma and Changing Attitudes
- Panel III: Improving and Strengthening Treatment Systems
- Panel IV: Connecting Services and Research
- Panel V: Addressing Workforce Issues.

THEMES OF THE NTP INITIATIVE

During the panel meetings and public hearings a series of themes emerged. These themes embody the guiding philosophy underlying the discussions of NTP participants.

- Alcoholism and drug dependence are treatable illnesses.
- Each individual in need of alcohol or drug treatment is unique.
- Clients and their families reflect the diversity of the population, including differences in race, ethnicity, socioeconomic status, education, religion, geographic location, age, sexual orientation, disability, and gender.
- Treatment benefits the individual client and his or her family, but also the public health, the public safety, and the public purse.
- Treatment should be timely, affordable, and of sufficient intensity and duration to be effective. It should be provided in a safe, flexible, and accessible environment.
- At times some individuals suffering from alcoholism or drug dependence may engage in improper or illegal behavior. Although such behavior may result from, or may be a sympton of the underlying illness, the illness does not excuse it. However, it is essential to recognize that the illness itself is a medical condition and a public health problem, for which effective treatments are available.
- Treatment should adhere to a high standard of quality.

GUIDELINES AND RECOMMENDATIONS

The first step recommended by all in improving treatment is to change the way the substance abuse treatment field and the Nation consider and address treatment issues. The goal is to shift the discussion from an emphasis on problems to a search for positive solutions. From each of the five panels, guidelines and recommendations for improving treatment were presented. NTP participants also agreed on five guidelines that encompass the specific recommendations and action steps developed by the expert panels. They are not presented in any priority order but rather as interdependent parts of the solution. In order to attain the goal of ensuring appropriate care to all who need it, **adequate resources, effective service systems, and higher standards of treatment** are prerequisites. The first three guidelines address these fundamental requirements:

INVEST FOR RESULTS The wise use of resources requires investment in treatment and services that in turn must produce the desired results.

Recommendations

- Close serious gaps in treatment capacity to reduce associated health, economic and social costs.
- Align financing and reimbursement mechanisms to ensure the most effective and efficient use of available resources.
- Establish standard insurance benefits for both public and private insurance that provide coverage for substance abuse and dependence equivalent to other medical conditions and that include a full array of appropriate treatment and continuing care.
- Set reimbursement rates and funding levels to cover reasonable costs of providing care, including evidence-based practice improvements; capital improvements and reinvestment; workforce recruitment, retention, and development; and care for persons without public or private insurance.

"NO WRONG DOOR" TO TREATMENT Effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services.

Recommendations

- Require appropriate assessment, referral, and treatment in all systems serving people with substance abuse and dependence problems.
- Ensure that in all systems individuals enter and become engaged in the most appropriate type and level of substance abuse treatment and that they receive continuing services at the level needed.
- Apply a commonly accepted, evidence-based model for the continuum of services and care for substance abuse and dependence across health, human services, and justice systems as well as in the substance abuse specialty sector.

COMMIT TO QUALITY Effective treatment and the wise use of resources depend upon ongoing improvement in the quality of care.

Recommendations

- Establish a system that more effectively connects services and research (CSR), with the goal of providing treatment based on the best scientific evidence. The system should specifically: a) promote consistent communication and collaboration among service providers, academic institutions, researchers, and other relevant stakeholders; and b) establish incentives and assistance for programs and staff in applying the new standards and treatment methods.

- Utilizing the CSR system, develop commonly accepted standards for the treatment field. Specifically: a) define evidence-based standards for quality of care and practices that apply to all systems and payors; b) derive or achieve consensus on critical data elements to measure quality of care and treatment outcomes for payors and providers; c) establish standards for education, training and credentialing of alcohol and drug treatment professionals and for other health and human service providers; and d) adopt best business practices for program management and operations.
- Attract, support, and maintain a high quality, diverse workforce, responsive to the client population.

NTP participants agreed that success would depend on following two final guidelines to select strategies and pursue specific recommendations. Both implicitly characterize the entire group of recommendations and action steps. However, participants emphasized their central importance through tangible recommendations.

CHANGE ATTITUDES Significant reduction in stigma and changes in attitudes will require a concerted effort based on systematic research.

Recommendations

- Engage the recovery community in all levels of discussion concerning substance abuse and dependence.
- Conduct systematic research to better understand how people at risk for, suffering from, or in recovery from alcohol and/or drug abuse are affected by multiple and overlapping forms of stigma, and to understand more fully the views and attitudes of various population groups regarding substance abuse and treatment.
- Conduct educational initiatives about alcohol and drug problems and effective treatments that promote the dignity of, and reduce stigma and discrimination against, people in recovery.

BUILD PARTNERSHIPS Effective efforts by individuals and organizations throughout the substance abuse treatment field to work with each other and with the many other people and groups throughout society who share a concern to improve substance abuse treatment will require specific encouragement and support.

Recommendations

- Encourage formation of effective groups that will: a) unite people with alcohol and/or drug problems, people in recovery, their families and friends, and b) bridge State/local systems of care and services that are responsible for various dimensions of the problem.
- Create forums where government agencies and private organizations can collaborate.
- Establish a Partnership Support Program that provides financial and other support to collaborative projects and groups.
- Establish "partnership-building" as a priority objective in all appropriate programmatic and funding activities.

CSAT'S NEXT STEPS

The NTP is an ongoing initiative. Initially, CSAT will publicize the NTP across the nation through distribution to key audiences and the general public; briefings of Federal agencies; and participation in conferences and community forums.

Over the past several years CSAT has embarked on a series of initiatives aimed at improving the substance abuse treatment system. These initiatives provide a foundation and starting point for many NTP recommendations.

CSAT plans to continue the initiative by focusing on recommendations for which CSAT has both the authority and resources. The first 10 recommendations to be addressed are representative of the five major guidelines that emerged from the five panel reports (see following page).

Recommendation	Sources (Panel Report)	Guideline
Develop a standard insurance benefit package.	I - Gap	*Invest for Results*
Develop reimbursement mechanisms aligned with treatment goals, incorporate performance measures and outcome standards, and ensure rates sufficient to cover both costs and a surplus to support reinvestment.	III - Systems	
Develop a taxonomy of services and treatment levels reflecting best practices in the field.	I - Gap III - Systems	*"No Wrong Door" to Treatment*
Develop the strategic plan for implementation of the Connecting Services and Research System (CSR).	IV - Services/ Research	*Commit to Quality*
Promote organizational cultures that improve the quality, effectiveness and efficiency of services through the adoption of best business practices for program management and operations.	III - Systems	
Develop a CSAT National Workforce Development Program to perform the action steps defined in the NTP panel's report.	V - Workforce	
Conduct a substance abuse language audit.	II - Stigma	*Change Attitudes*
Conduct science-based marketing research to provide the foundation for a social marketing plan.	II - Stigma	
Enter into formal memoranda of agreement with the appropriate Federal partners for the development and operation of the CSR.	IV - Services/ Research	*Build Partnerships (Commit to Quality)*
Define and support processes for cross-system consensus on: a) evidence-based treatment protocols and b) methods and measures for continuous monitoring of quality of care.	I - Gap	

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Introduction and Background

The problem of substance abuse and dependence has long troubled the Nation, requiring balance among concerns for public safety, moral values, and health. A focus on treatment to help people recover and stop using or abusing substances does not resolve possible conflicts among these concerns, but can help defuse them by turning our energies toward a common solution.

Since the repeal of Prohibition in 1933, the sale and consumption of alcohol have been legal, though highly regulated. The sale or purchase of drugs such as marijuana, heroin, and cocaine remains against the law. At least since the 1950s, however, addiction also has been viewed as a medical problem. In 1970, the Hughes* Act created the National Institute on Alcohol Abuse and Alcoholism (NIAAA), turning an important corner — national recognition that alcoholism is a disease. Within a few years, the creation of the National Institute on Drug Abuse (NIDA) expanded the Federal focus on addiction.

Thirty years later, advances in science have reshaped our understanding of addiction and created an array of effective behavioral and pharmacological interventions (Simpson, 1999; O'Brien and McLellan, 1996; SAMHSA's NTIES, 1997; SAMHSA's SROS, 1998). Addiction treatments now can be as effective as treatment of other long-term, relapsing illnesses, such as diabetes, hypertension, and asthma, so long as the treatment is "well-delivered and tailored to the needs of the particular patient" (Leshner, 1999).

We continue to struggle with the implications of these advances. If alcoholism and drug addiction are diseases, what treatments are best and who should receive them? Who should pay for that treatment? How should it be provided?

The Center for Substance Abuse Treatment (CSAT) was established within the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1992 to focus national efforts on improving and expanding the availability of treatment for alcohol and drug abuse and dependence. CSAT began the National Treatment Plan Initiative (NTP) to build on recent advances in the field, bring together the best, science-based ideas about improving treatment, and specify actions that could translate knowledge into practice. The goal is to "change the conversation" about substance abuse to focus on a positive agenda that ensures appropriate alcohol and drug treatment for all who need it.

Paralleling the advances in science, a diverse set of services has emerged to provide treatment for alcoholism and drug abuse. A brief overview of the current system shows that:

- Between 13 million and 16 million people need treatment for alcoholism and/or drugs in any given year, but only 3 million receive care (SAMHSA, 1999; Institute of Medicine, 1997).

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*Senator Harold Hughes of Iowa, a leading advocate for treatment and research of alcohol abuse and alcoholism, exemplified the potential for leadership by people in recovery.

- Estimated annual spending for substance abuse prevention and treatment in 1997 was $11.9 billion. Of this amount, public spending accounted for $7.3 billion or nearly two-thirds, compared to just over half in 1986 (Coffey; Mark; King; Harwood; McKusick; Dilonardo; Buck; 2000).
- The Federal Government accounts for nearly one-third of national expenditures on substance abuse treatment, through Medicare, the Federal share of Medicaid, the Department of Defense, the Department of Veterans Affairs, and the Substance Abuse Prevention and Treatment (SAPT) Block Grant (Coffey, et al., 2000).
- In 1999, the SAPT Block Grant provided $1.6 billion for alcohol and drug abuse treatment, supporting treatment for approximately 300,000 individuals, together with a broad array of prevention, monitoring, and support activities.
- In 1993, 70 percent of drug users were employed and most had private health insurance, however, 20 percent of public treatment funds were spent on people with private health insurance due to limitations in their insurance coverage (ONDCP, 1999).
- Approximately 10,800 treatment facilities existed in the United States in 1997. More than 75 percent of all facilities each served fewer than 100 clients. More than 80 percent of facilities were private organizations (not-for-profit and for-profit). However, public funds paid for nearly two-thirds of all treatment (SAMHSA, Uniform Facility Data Set (UFDS), 1999).
- Of more than 929,000 clients in treatment in 1997, approximately 55 percent were in private, not-for-profit facilities (SAMHSA, UFDS, 1999).
- Nearly 69 percent of all clients treated were men. Over half of all clients in 1997 were under the age of 35 (SAMHSA, UFDS, 1999).
- The Surgeon General's 1999 *Report on Mental Health* observes that as many as half of all people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives (DHHS, 1999).
- Comorbidity of substance abuse and mental illness exacerbates symptoms and often leads to treatment noncompliance, more frequent hospitalization, greater depression and likelihood of suicide, incarceration, family friction, and higher services use, and cost (DHHS, 1999).
- In addition, the Surgeon General's 1999 *Call to Action to Prevent Suicide* recognizes the role of substance abuse disorders: "Suicidal behavior typically occurs in the presence of mental or substance abuse disorders — illnesses that impose their own direct suffering... [I]mproved detection and treatment of mental and substance abuse disorders represent a primary approach to suicide prevention" (DHHS, 1999).

- Studies show that with drug treatment, primary drug use decreases by nearly half, reported alcohol and drug-related medical visits decline by more than half, criminal activity decreases by as much as 80 percent, and client financial self-sufficiency improves (e.g., employment increases, welfare receipt and homelessness decline) (NTIES, 1997).

The NTP seeks to respond to these facts and to the national goals and objectives related to substance abuse and health that have been established by the Office of National Drug Control Strategy and the Department of Health and Human Services. Specifically, the National Drug Control Strategy includes two goals and a series of objectives that involve improving treatment:

Goal 2 Increase the safety of America's citizens by substantially reducing drug-related crime and violence.

Objective 5: Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

Goal 3 Reduce health and social costs to the public of illegal drug use.

Objective 1: Support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse.

Objective 2: Reduce drug-related health problems, with an emphasis on infectious diseases.

Objective 3: Promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes drug testing, education, prevention, and intervention.

Objective 4: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Healthy People 2010 sets out the Nation's agenda to lengthen and improve the quality of life and to eliminate health disparities among different segments of the population (DHHS, 2000). It identifies the following health impacts of substance abuse:

> *"Alcohol and illicit drug use are associated with child and spousal abuse; sexually transmitted diseases, including HIV infection; teen pregnancy; school failure; motor vehicle crashes; escalation of healthcare costs; low worker productivity; and homelessness. Alcohol and illicit drug use also can result in substantial disruptions in family, work, and personal life.*

> *Alcohol abuse alone is associated with motor vehicle crashes, homicides, suicides, and drowning — leading causes of death among youth. Long-term heavy drinking can lead to heart disease, cancer, alcohol-related liver disease, and pancreatitis. Alcohol use during pregnancy is known to cause fetal alcohol syndrome, a leading cause of preventable mental retardation (PHS, 2000).*

Goal 26 of *Healthy People 2010* is to "Reduce substance abuse to protect the health, safety, and quality of life for all, especially children." The objectives selected to measure progress for this Leading Health Indicator include increasing the proportion of adolescents and the proportion of adults not using alcohol or any illicit drugs during the past 30 days and reducing the proportion of adults engaging in binge drinking during the past month.

The success of these national efforts to stem alcohol and drug problems requires ongoing improvement in the quality and availability of treatment services for substance abuse and dependence. In recent years, many thoughtful recommendations have been developed. The list of previous efforts is extensive. Current and proposed treatment strategies are being tested in the field and reported by SAMHSA, NIH (NIDA and NIAAA), and other Federal organizations. In addition to ONDCP, the IOM, the General Accounting Office (GAO), and the Office of the Inspector General for the Department of Health and Human Services (OIG, DHHS) have issued numerous reports on drug and alcohol research, treatment, and managed behavioral healthcare. Many research and consulting organizations, national foundations, and trade and professional associations have also issued reports.

Some of these efforts have succeeded and others show promise. Further progress will require a sustained and coherent strategy that can address the whole range of issues associated with alcohol and drug problems. That is the purpose for the NTP Initiative.

To organize thinking about such a broad set of concerns, the NTP leadership (key CSAT staff in consultation with a steering group comprising senior leaders from influential groups within the field) selected five "domains" that encompass the whole array of treatment concerns while highlighting strategic issues central for the field: Closing the Treatment Gap, Reducing Stigma and Changing Attitudes, Improving and Strengthening Treatment Systems, Connecting Services and Research, and Addressing Workforce Issues.

For each domain, the NTP leadership organized a panel of experts representing diverse knowledge, experience, and views. The panel chairs were carefully chosen to be experienced, senior leaders who could shape consensus among the group. Panel members were charged with considering and building on the work of any groups that had issued reports or recommendations relevant to that domain. In particular, each panel was to determine whether previous recommendations had been implemented, and if so, whether additional action is needed. If a recommendation had not been implemented, the panel explored why that was true and whether a different approach was needed. In sum, rather than duplicating prior work, the panels focused on what should be done in the future. The work of the panels is more fully described below in the Approach and Process section and in *Changing the Conversation: Panel Reports, Public Hearings and Participants.* To further guide the initiative and develop the themes, CSAT sponsored a series of six regional public hearings. These hearings were aimed at obtaining additional information and views, particularly from front-line providers, policymakers, and people in recovery and their families.

Seven major NTP themes emerged from the panel meetings and public hearings. These themes represent the philosophy that guided the discussions and the NTP Initiative as a whole.

THEMES OF THE NTP INITIATIVE

- Alcoholism and drug dependence are treatable illnesses. Individuals suffering from these illnesses deserve effective, state-of-the-science treatment. However, public attitudes have not kept up with advances in knowledge, leading to doubt about the value of treatment and unwillingness to invest resources in treatment.
- Each individual in need of alcohol or drug treatment is unique. To be successful treatment must focus on the client and the client's family. The goal of treatment is to help the client recover — to overcome the illness and lead a healthy and productive life.
- Clients and their families reflect the diversity of our population, including differences in race, ethnicity, socioeconomic status, education, religion, geographic location, age, sexual orientation, disability, and gender. Treatment must be respectful and empowering to the individual. It should be responsive to the needs of different cultures and population groups, and should acknowledge and adapt to the situation of each client's family, social support structure, and community environment.
- Treatment benefits the individual client and his or her family, but also the public health, the public safety, and the public purse. Society must weigh the costs of effective treatment against the costs of failing to provide treatment.
- Treatment should be timely, affordable, and of sufficient intensity and duration to be effective. It should be provided in a safe, flexible, and accessible environment. The system of care must provide a comprehensive array of treatment alternatives and support practitioner and provider efforts to deliver quality care.

- At times, some individuals suffering from alcoholism or drug dependence may engage in improper or illegal behavior. Although such behavior may result from, or may be a symptom of the underlying illness, the illness does not excuse it. However, it is essential to recognize that the illness itself is a medical condition and a public health problem, for which effective treatments are available.

- Treatment should adhere to a high standard of quality. To this end, the system must promote the development and application of new knowledge and treatment approaches as well as innovations that improve efficiency and responsiveness. The system should make the best possible use of resources provided for care, and must be fully accountable to clients and families, to funding sources, and to the public.

Guidelines and Recommendations to Improve Treatment

The National Treatment Plan Initiative envisions a society in which people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated. We envision a society in which substance abuse/dependence is recognized as a public health issue, a treatable illness for which individuals deserve treatment. We envision a society in which high-quality services for alcohol and drug problems are widely available and where treatment is recognized as a specialized field of expertise.

The NTP seeks to build a seamless system offering high-quality and effective treatment based on individual need, regardless of how or where a person enters treatment. The goal is to ensure that quality treatment is available for all who need it.

The first step in improving treatment is to change the way the substance abuse field and the Nation consider and address treatment issues. Pervasively negative attitudes currently surround people seeking treatment and those in recovery. The goal is to shift the discussion from an emphasis on problems to a search for positive solutions. NTP participants agreed on five guidelines that encompass the specific recommendations and action steps developed by the expert panels. They are not presented in any priority order but rather as interdependent parts of the solution.

The NTP is directed toward a broad audience: government agencies, policymakers, practitioners and providers, foundations, allied service systems, and people with substance abuse and dependence problems and their families and friends. No one group or organization has the authority or resources to do it all. Some ideas may be put in place quickly and easily. Others may require more time, effort, and modification.

Taken together, the guidelines, recommendations, and action steps provide direction and a source of ideas on improving treatment for substance abuse and dependence in our society. They reflect the collective views of the participants in the NTP "conversation" over the past eighteen months. For a more detailed examination of the issues and recommendations, please refer to the companion volume, *Changing the Conversation: Panel Reports, Public Hearings, and Participants.*

In order to attain the goal of providing appropriate care to all who need it, NTP participants agreed that **adequate resources, effective service systems, and higher standards of treatment** are prerequisites. The first three guidelines address these fundamental requirements:

INVEST FOR RESULTS The wise use of resources requires investment in treatment and services that in turn must produce the desired results.

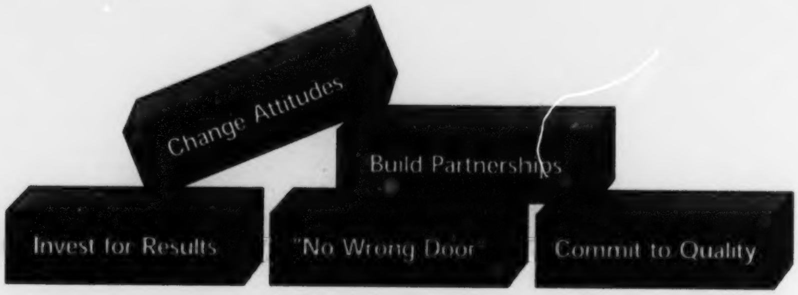
"NO WRONG DOOR" TO TREATMENT Effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services.

COMMIT TO QUALITY Effective treatment and the wise use of resources depend upon ongoing improvement in the quality of care.

NTP participants agreed that success would depend on following two final guidelines to select strategies and pursue specific recommendations. Participants chose to clearly define the guidelines by developing tangible recommendations that implicitly characterize the entire group of recommendations and action steps.

CHANGE ATTITUDES Significant reduction in stigma and changes in attitudes will require a concerted effort based on systematic research.

BUILD PARTNERSHIPS Effective efforts by individuals and organizations throughout the substance abuse treatment field to work with each other and with the many other people and groups throughout society who share a concern to improve substance abuse treatment will require specific encouragement and support.



The National Treatment Plan is intended to provide an overarching framework that shows how all of the varied current and future activities in organizing, financing, and quality improvement for substance abuse treatment can relate, and that also may support creative and collaborative initiatives to improve substance abuse treatment in the Nation. This report summarizes the concerns of the various panels and presents focused recommendations for future steps that may be taken by a variety of Federal agencies, State and local entities, treatment providers, researchers, consumers/families, and funding bodies. The recommendations, however, should not be considered to be exhaustive, nor should the action steps be thought of as the only reasonable strategies that might be pursued to improve substance abuse treatment. In fact, CSAT views the National Treatment Plan Initiative as the first step in an evolutionary process, to be adapted as additional evidence emerges about administrative, clinical, and policy issues.

The remainder of this section presents each of the guidelines and its associated recommendations together with suggested action steps and a "discussion" that further explicates the proposed approach and the thinking behind it. While many of these are based on ideas and discussions in several panels, the referenced panel reports provide the primary source.

INVEST FOR RESULTS

Recommendations

- Close serious gaps in treatment capacity to reduce associated health, economic and social costs.
- Align financing and reimbursement mechanisms to ensure the most effective and efficient use of available resources.
- Establish standard insurance benefits for both public and private insurance that provide coverage for substance abuse and dependence equivalent to other medical conditions and that include a full array of appropriate treatment and continuing care.
- Set reimbursement rates and funding levels to cover reasonable costs of providing care, including evidence-based practice improvements; capital improvements and reinvestment; workforce recruitment, retention, and development; and care for persons without public or private insurance.

> "A DRUG ADDICT CAN DO INCREDIBLE THINGS FOR HIMSELF AND HIS COMMUNITY ONCE HELP IS FOUND. THERE ARE PEOPLE... WHO WANT TO GET HELP THROUGH TREATMENT CENTERS, BUT THEY MAY DIE BEFORE THEIR CHANCE COMES."
>
> — *Person in Recovery*

Suggested Action Steps

- Provide sustained funding to support State and local involvement in assessing treatment needs at the community and regional levels.
- Incorporate performance measures and outcome standards, based on continuing treatment for people who need it, to guide resource allocation decisions by all payors.
- Develop a model benefit, reflecting broad agreement among interested parties to serve as a guideline for what constitutes equivalent coverage.
- Increase both private and public insurance coverage, and government program dollars (Federal, State and local) for substance abuse treatment.

- Convene a national task force to propose and test improved reimbursement models that align financial incentives with treatment system goals.
- All payors should review and adjust their rate structure on an ongoing and regular basis, not less than every two years.
- CSAT should publish guidelines for establishing the cost of services.

Discussion

The NTP's objective is to use resources well, to get the greatest return for the investment in treatment. Today, resources are not maximized, and (even if they were) the resources available fall far short of the demonstrated need. Improving treatment will require adequate resources. These recommendations address both the need to improve the way we use resources and the need for additional resources. Funds must be better leveraged from existing sources, such as the acute healthcare system and employer-sponsored health insurance, the pool of resources available must be expanded. Investing in effective treatment can produce savings for employers and for public health, safety, and human services systems. Failure to act means that the country will continue to pay for the results in human suffering, lost productivity, higher healthcare costs, family problems, and compromised quality of life in our communities.

"THERE ARE DISPARITIES IN THIS NATION THAT ARE ECONOMIC, THAT ARE CULTURAL — SO I WOULDN'T TALK ABOUT TREATED AND UNTREATED. I'D TALK ABOUT THE DISPARITY THAT EXISTS IN AMERICA AROUND THIS DISEASE."

— Primary Care Expert

Although the current treatment gap is not precisely known, clearly it is wide. Of the estimated 13 million individuals in need of alcohol and drug treatment, approximately 10 million are not receiving it (see *Panel I Report: Closing the Treatment Gap*). Of the people who are "in treatment," many may have no access to the most appropriate treatment for their condition or may face limits on length of stay that inhibit treatment effectiveness. Sufficient public and private resources must be available and appropriately deployed to deliver the quantity, the types, and the levels of care needed. Quantity should be understood to combine frequency, duration, and intensity of treatment. For certain groups, such as people in rural areas, women and Native Americans, the problem is especially acute.

Dedicated providers must have a greater capacity for community care based on standards of excellence. Some problems with our existing use of resources include a disparity among different communities in the availability and accessibility of services, especially for people with language or cultural differences. Systems must include effective programs of outreach and engagement to bring people into appropriate treatment. Service systems should provide a full spectrum of care, including multiple treatments for various forms of alcohol or drug dependence, and alternatives that are more acceptable and effective for different individuals and families.

It is essential to increase the capacity to identify and respond to changes in community-level needs and treatment systems. National and statewide assessments are useful, but aggregation tends to mask specific patterns of need in individual communities. Existence of even a relatively well funded treatment program in a community does not mean that most people within that community will have access to the type of treatment that can best help them. To fully understand the gap, it is important to assess the situation from the point of view of an individual in need of treatment and look beyond aggregated statistics.

> **"THE GAPS ARE GREATER AMONG THE POPULATIONS THAT WE KNOW ARE MORE VULNERABLE, SO WE HAD BETTER MAKE SURE THAT THEY GET CARE."**
>
> — *Local Provider*

Financing should support both the type and the level of treatment that people need. Current insurance mechanisms reflect historical views of substance abuse and dependence and perpetuate outdated assumptions about treatment effectiveness. Alcoholism and drug dependence are medical conditions, as deserving of treatment as any other. Partial or inappropriate treatment is both costly and ineffective and fuels the attitude that treatment does not work. Treatment may have an acute phase, but a long-term recovery plan is needed, which might include ongoing support and follow-up as well as additional treatment for some. Like other relapsing illnesses, alcohol and drug dependence may require multiple episodes of treatment and continuing care. Expectations about what constitutes treatment success should conform to this reality.

Services must be a good investment. To accomplish this, providers should be prepared to change or even to abandon approaches shown to be less effective than others, and to demand a high standard of quality. For example, providers wishing to receive reimbursement for substance abuse screening, assessment, and/or treatment should employ evidence-based treatment protocols and strategies, standard practice guidelines, and recognized best practices wherever possible. Providers should continuously monitor quality of care using standardized methods and measures. Funding and reimbursement should be linked to performance and outcomes (see *Panel III Report: Improving and Strengthening Treatment Systems*).

While efficiency must always be a goal, it is important to recognize that change and improvement bring added cost. Much of the current treatment system consists of not-for-profit service providers and public agencies that have particular problems gaining access to the funds needed for staff development, higher salaries to retain and attract the best workers, and information systems to support management and monitor performance and quality. In order to ensure that the treatment system can recruit and retain the services of competent staff, we must make sure that they have adequate salaries, as well as access to training and professional development (see *Panel III* and *V Reports: Improving and Strengthening Treatment Systems; Addressing Workforce Issues*).

"AT AGE 23 I WAS ADMITTED TO A GENERAL HOSPITAL AS A RESULT OF ALCOHOL POISONING. ALTHOUGH I HAD NO TREATMENT HISTORY I WAS DIAGNOSED WITH ALCOHOLISM BY A PROMINENT PSYCHIATRIST WHO RECOMMENDED A PREFRONTAL LOBOTOMY. HIS RECOMMENDATION WAS BASED ON CURRENT RESEARCH FINDINGS. INSTEAD, MY FAMILY FOUND AN ALCOHOLISM TREATMENT CENTER BASED ON A TWELVE-STEP MODEL AND, AS A RESULT, I AM NOW A HAPPY, RESPONSIBLE MEMBER OF SOCIETY."

— Member, County Council on Alcoholism and Drug Dependence

NO WRONG DOOR TO TREATMENT

Recommendations

- Require appropriate assessment, referral, and treatment in all systems serving people with substance abuse and dependence problems.
- Ensure that in all systems individuals enter and become engaged in the most appropriate type and level of substance abuse treatment and that they receive continuing services at the level needed.
- Apply a commonly accepted, evidence-based model for the continuum of services and care for substance abuse and dependence across health, human services, and justice systems as well as in the substance abuse specialty sector.

Suggested Action Steps

- CSAT should support the development of standards for treatment for those agencies outside the substance abuse treatment system, provide technical assistance, and facilitate intergovernmental links.
- Develop a client-focused, evidence-based model of treatment, including screening, intervention, assessment, engagement, individual and group therapies, aftercare, and relapse prevention.
- As an initial step in building that model, develop a taxonomy of treatment services to provide a consistent description of substance abuse services and to serve as a framework for reimbursement and billing arrangements.
- Attach protocols for providing evidence-based treatment to State and local funding streams, to ensure effective treatment, regardless of point of entry.

- Convene key systems representatives to clarify system responsibilities, requirements, goals, capacities, and priorities that will provide the basis for written agreements and standardized tools and practices among those engaged in treatment and treatment-related services.
- CSAT should analyze and compare current technologies for assessment, placement, treatment planning, and treatment implementation.
- Individualized treatment should be the standard required by State substance abuse authorities, State accrediting and licensing authorities, and other payors.
- Treatment practitioners should be trained to implement individualized treatment planning and to use the tools and practices required to support individualized treatment.

Discussion

The NTP seeks to ensure effective, high-quality and clinically appropriate treatment for all individuals in need of treatment regardless of individual or organizational barriers that may impede their access to care. Despite growing recognition that alcohol and drug treatments are effective, many such barriers remain. These recommendations start from the fact that people with substance abuse and dependence problems are unique individuals who do not fit neatly into service or system categories. The goal is to ensure that an individual needing treatment — regardless of the door or system he or she enters — will be identified and assessed, and will receive treatment either directly or through appropriate referral.

> "NO WRONG DOOR FOR TREATMENT [MEANS] THAT PEOPLE WHEREVER THEY ARE SHOULD BE IDENTIFIED AND GET TREATMENT." — *Local Judge*

To further this goal, the NTP recommendations and action steps propose developing both a treatment model and a system model. Each model incorporates recognition of individual variation and the consequential need for multiple treatment alternatives and a continuum of services. Both models should be designed to apply to all persons who may utilize the substance abuse system or overlapping systems, and account for the individual factors that impact individuals and families affected by this disorder. The full array of available services contemplated by the models include screening, intervention, assessment, engagement, individual and group therapies, continuing care and relapse prevention (see *Panel I Report: Closing the Treatment Gap* and *Panel III Report: Improving and Strengthening Treatment Systems*).

> "IT'S A JOINT RESPONSIBILITY — STATE, FEDERAL AND LOCAL — AND WE NEED TO TALK ABOUT THE WHOLE ISSUE [OF] WHAT ROLE EACH HAS TO PLAY IN CLOSING THE GAP."
>
> — *State Substance Abuse Agency Director*

The specific aspects of the proposed treatment and system models, in effect, speak to issues that have been identified repeatedly in current treatment programs:

- Treatment plans should be based on an individual's needs and should respond to changes as he or she progresses through stages of treatment;
- The system and services should be readily accessible to the community, with geographically convenient entry points;
- Systems should provide timely, affordable and comprehensive treatment on request;
- Creative outreach strategies may be needed to encourage some people to engage in treatment;
- Programs may need to change expectations and program requirements to meet clients at their stage of readiness to change, and develop accountable treatment plans that enhance responsibility and measurable results; and
- The overall system — from identification through maintenance — should be seamless and include multiple forms of treatment and support, based on evidence-based practices.

Individuals in need of treatment for substance abuse and dependence do not fall exclusively within the purview of the "substance abuse system." They may appear in any of a variety of service systems, including primary healthcare, mental health, social service, justice, education, employment and housing. Each of these allied systems has a separate mission and responsibility, and the need for substance abuse/dependence treatment does not absolve the client of responsibility to meet his or her obligations to that system. However, where substance abuse/dependence is not a system's primary focus, that system does have a responsibility to identify clients suffering from this illness.

> "SUBSTANCE ABUSE TREATMENT CANNOT BE A CATEGORICAL SERVICE. IT MUST BE LINKED WITH OTHER SOCIAL INSTITUTIONS AND COMMUNITY RESOURCES."
>
> *- Local Provider*

The fact that the client is identified through an allied system does not change the nature of the illness or the need for the same quality of treatment as others with similar problems. For this reason, it is particularly important to develop a common framework for treatment, including standardized tools and practices, among the allied systems where clients with alcoholism or drug problems are most likely to be present. The framework would be responsive to the differing responsibilities and priorities of each system, while assuring that treatment meets professional standards.

The development and implementation of such models will require significant new levels of cooperation between and among allied systems for health, human services and justice. The need for collaboration between the substance abuse and mental health systems to provide appropriate treatment for the large number of persons with co-occurring disorders is especially acute.

COMMIT TO QUALITY

Recommendations

- Establish a system that more effectively connects services and research (CSR), with the goal of providing treatment based on the best scientific evidence. The system should specifically: a) promote consistent communication and collaboration among service providers, academic institutions, researchers, and other relevant stakeholders; and b) establish incentives and assistance for programs and staff in applying the new standards and treatment methods.
- Utilize the CSR system to develop commonly accepted standards for the treatment field. Specifically: a) define evidence-based standards for quality of care and practices that apply to all systems and payors; b) derive or achieve consensus on critical data elements to measure quality of care and treatment outcomes for payors and providers; c) establish standards for education, training and credentialing of alcohol and drug treatment professionals and for other health and human service providers; and d) adopt best business practices for program management and operations.

> "WE CANNOT [SIMPLY] DEMAND THAT TREATMENT PROGRAMS TAKE ON ADDITIONAL...INITIATIVES THAT ARE FELT TO BE USEFUL, BUT WE MUST INCREASE THEIR CAPACITY TO MAKE USE OF THEM."
>
> — *Services Research Expert*

- Attract, support, and maintain a capable, diverse workforce, responsive to the client population.

Suggested Action Steps

- CSAT should make available to providers the necessary training and support to implement the standards and measures.

- CSAT, State substance abuse authorities and trade associations should support the development and dissemination of training and educational materials to foster skill development for providers and provider organizations, including:
  - Access to capital resources;
  - Case studies on the application of exemplary business practices;
  - Board governance;
  - Human resources;
  - Information management; and
  - Finance.
- In support of the previous recommendations, CSAT should earmark a portion of its technical assistance resources, including the Addiction Technology Transfer Centers (ATTC) and the National Leadership Institute (NLI), for implementation and adoption of exemplary business practices. Substance abuse treatment organizations should:
  - Examine their business infrastructure and upgrade systems and operations to conform with exemplary business practices;
  - Monitor program outcomes, performance, and satisfaction and use that information to guide and improve program operations and service delivery, as well as to inform payors, community, consumers, and staff about program performance, productivity, and efficiency;
  - Invest in staff development and training to ensure a culturally sensitive organization that values professional and business skills.
- A new program should be established at the national level to lead and support the development of the alcohol and drug treatment workforce. To support the development of the program the following activities should be conducted:
  - Develop a comprehensive report on the state of the workforce;
  - Develop and monitor cross-disciplinary competency guidelines;
  - Facilitate a multi-disciplinary process to develop a core curriculum which will form the basis of credentialing standards;

- Monitor the inclusion of basic addiction-related curricula in education and training programs.

Programmatic outcomes should include improved compensation, career ladders, and staff development.

Discussion

To guarantee that treatment is effective and that payors will receive full value for what they spend, a commitment to the quality of care is essential. Commitment to quality in turn requires a sound base of evidence, a process for deriving and enforcing standards, a capable workforce, and the resources necessary to realize these goals. The NTP recommendations are designed to improve how new knowledge is moved swiftly and effectively from research into application.

The recommendation for a new system to connect services and research (CSR system) reflects experience in this field and in many others. Given the significant strides made in the past several years in our knowledge about substance abuse and the brain, as well as in the development of evidence-based practice, it is essential that this knowledge be utilized to improve treatment quality. Despite numerous reports and exhortations, a number of fragmented programs, and the best intentions of all parties, the best knowledge still largely fails to be adopted in practice. The purpose of this recommendation is to create an overall structure capable of coordinating the entire set of elements involved. (The system is described in detail in *Panel Report IV: Connecting Services and Research.*)

Treatment programs must incorporate new research results in their treatment practices, implement quality improvement systems and performance standards, and employ well-trained staff. Practice concerns must help shape the research agenda, and new knowledge must move swiftly and effectively from research into application. This interactive process should establish evidence-based practices, treatment and management standards, performance measures, and quality indicators, as well as training programs for staff. Since creating and enforcing standards of quality may require changes in well-established treatment practices and program configurations, particular attention should go to establishing incentives and assistance for programs and staff in applying the new standards and treatment methods.

> **"WE SHOULDN'T POLARIZE RESEARCHERS AND PROVIDERS. PUT SIMPLY, PROVIDERS NEED TO HAVE INPUT TO THE RESEARCH AGENDA AND RESEARCHERS NEED TO PAY ATTENTION TO THE OUTCOMES OF RESEARCH AND MAKE CHANGES."**
>
> *— Regional Knowledge Transfer Expert*

The goal of this holistic approach is to ensure that research findings in alcohol and drug treatment services that are useful to the field are produced and effectively infused into practice. To date, much more emphasis has been placed on knowledge development and knowledge transfer, and less effort devoted to ensuring that service providers are able to obtain the technical and problem-solving assistance, as well as the financing necessary to implement innovations. The lack of reimbursement or other payments to defray the cost of training, changing procedures, and other implementation costs is a significant barrier to change. Thus, there is a particular need to focus on knowledge application strategies that go beyond knowledge transfer and dissemination, to ensure that new practices are effectively adopted in the field.

> "OVER THE LAST TWENTY-EIGHT YEARS, THE BIGGEST FAILURE IN THE SUBSTANCE ABUSE TREATMENT FIELD IS THE LITTLE IMPACT WE HAVE HAD FROM RESEARCH ON TREATMENT."
>
> — *Local Judge*

An effective system will depend on coordinated leadership among providers, researchers, CSAT, NIDA, NIAAA and other relevant Federal agencies. It should involve the national, regional, and State/local levels, and draw on the views and participation of a wide range of interested parties, including clients and families, policymakers, and others.

This recommendation takes previous proposals a step further by involving service providers and researchers in mutually supportive roles throughout the process of developing and applying knowledge. The goal is to enable the service delivery community and the research community to work together more productively to improve service delivery. The proposed CSR system should build on and support the independent efforts of the various participants, help to coordinate their efforts, and fill gaps that currently hinder necessary connections. Service providers should be full partners in the development of research agendas and research designs that are responsive to the treatment concerns and practical situations of treatment settings serving as research sites. A national panel would work to facilitate communication among CSAT, NIDA, NIAAA and other Federal agencies, and to connect the researcher and provider communities at regional and State levels.

Setting standards should be a collaborative process, involving all relevant parties. Standards are currently set by various organizations and professions, leading to confusion and frustrating efforts to secure adoption by service providers and by quality assurance systems. A common set of standards would serve as a core; additional specialized standards may be added as required.

The standards should support treatment that is culturally sensitive and responsive to the unique needs of individuals and families from different population groups; that is client-centered, respectful and empowering to the individual; and that is free from the stigma often associated with alcohol and drug problems. Standards should be based on the best evidence, and provide for continuing improvement. At the same time, the design of standards and quality assurance and improvement systems should incorporate consideration of the cost of implementation.

Treatment programs, payors and regulators should promote the quality, effectiveness and efficiency of services through the adoption of best business practices for program management and operations. These may include, for example: effective governance and leadership for the Board of Directors and senior management; management and operation of human resources, marketing and finance; information and data management operating systems; and capital and facilities. Treatment programs should fully involve the client population and the community they are serving (see *Panel III Report: Improving and Strengthening Treatment Systems*).

Treatment cannot improve without enhancing the workforce responsible for delivering treatment. The alcohol and drug treatment system of the future should be able to provide integrated, comprehensive treatment through a range of well-trained professionals. Treatment should include state-of-the-art clinical and information technology. Providers and practitioners need time, training, and support to enable them to participate in influencing the national research agenda, and to incorporate research findings to guide treatment practice.

To achieve these goals, the alcohol and drug treatment workforce must be grounded in training, clinical supervision, education, and the certification processes that reflect the evolving knowledge base as well as the demand of funding sources and quality assurance standards for higher levels of professionalism. At the same time, the field must find ways to preserve the important elements of experience and commitment that have long been provided by the significant number of staff who are in recovery and whose primary training has been experiential.

For all staff, appropriate compensation and opportunities for increased responsibility based on competency are needed to ensure that the best possible workforce can be recruited and retained. As recommended (see above, *Invest for Results*), reimbursement mechanisms should include rates sufficient to cover reasonable costs, including the cost of competitive compensation and staff development.

The specific Recommendation for a national program to support workforce development responds to the current lack of any focal point for addressing these issues. Among the elements the program might address are: a comprehensive report on the state of the workforce; cross-disciplinary competency guidelines; core curricula; inclusion of basic alcohol and drug dependence-related information in education and training programs for professionals in health and human services (and other related fields) at the undergraduate, graduate, and post-graduate/continuing education levels; and attention to alcohol and drug treatment issues by all accrediting and certifying/re-certifying agencies (see *Panel V Report: Addressing Workforce Issues*).

CHANGE ATTITUDES

Recommendations

- Engage the recovery community in all levels of discussion concerning substance abuse and dependence.
- Conduct systematic research to better understand how people at risk for, suffering from, or in recovery from alcohol and/or drug abuse are affected by multiple and overlapping forms of stigma, and to understand more fully the views and attitudes of various population groups regarding substance abuse and treatment.
- Conduct educational initiatives about alcohol and drug problems and effective treatments that promote the dignity of, and reduce stigma and discrimination against, people in recovery.

Suggested Action Steps

- Begin with a language audit to determine problems or opportunities inherent in the language currently used in the field and in public discussion.

> "IF THIS IS A CHRONIC DISEASE, WHY DON'T WE TREAT IT LIKE ONE INSTEAD OF SEPARATE FROM ALL OTHER CHRONIC DISEASES?"
>
> — *National Research Expert*

- Identify and acquire necessary resources to implement a comprehensive social marketing strategy.
- Design and execute a public education campaign, with an identifiable campaign theme.
- Support development of a more active and visible recovery community.
- Highlight success stories of recovering people and their families, to put a human face on addiction and recovery.
- CSAT and others should collaborate to create tools, toolboxes, message and educational materials, and guidelines for grassroots efforts and public education campaigns.

Discussion

The need to change attitudes is a consistent theme throughout the panel reports. Panel II's work represents a concerted effort to address the problem of negative attitudes and stigma affecting people with alcohol and drug problems and those in recovery. (See *Panel II Report: Reducing Stigma and Changing Attitudes.*) These attitudes affect not only the person with substance abuse and dependence problems, but families, practitioners and providers, employers, policymakers and many others who make decisions affecting the availability of treatment. Previous efforts have tended to focus on preventing use or abuse of various substances. Some of these efforts, by stigmatizing alcohol and drug problems, may also contribute to negative attitudes toward treatment and recovery.

The recommendations are designed to reverse the pervasively negative attitudes that currently surround people seeking treatment and those in recovery. Society often labels substance abuse as a moral weakness rather than as an illness, creating the underlying stigma attached to people with alcohol and drug problems, people in or seeking recovery and their families, significant others, and support networks. There is a persistent but mistaken impression that treatment does not work. Many people confuse the illness with behavior that may constitute indications, symptoms or results of the illness. And, people with alcohol or drug problems often suffer from additional compounding stigmas — based on race, ethnicity, gender, sexual orientation, and other factors (such as mental illness). These negative dimensions often reinforce each other.

The discussion starts from the proposition that alcoholism and drug dependence are medical conditions and public health problems, for which effective treatments are available. At times, some individuals suffering from alcoholism or drug dependence may engage in improper or illegal behavior. While such behavior may result from, or may be a symptom of the underlying illness, it is not excused by the illness. However, it is essential to recognize that the illness itself is a medical condition and a public health problem, for which effective treatments are available.

The Americans with Disabilities Act (ADA) of 1990 prohibits discrimination against persons with a disability, and also against those regarded by others as having a disability. Laws, policies and practices inconsistent with the ADA encourage prejudicial beliefs and discrimination against individuals in recovery from alcohol and drug problems, hinder diagnosis and entry into treatment, and deprive people in recovery of their basic human rights. These recommendations seek to combat discrimination against people in recovery, including those in treatment. They do not comment on laws and policies concerning current addiction.

The recommendations also seek to change attitudes about alcohol and drug treatment that prevail among people with substance abuse and dependence problems, practitioners and providers, members of allied service systems, students, policymakers, opinion leaders, and the general public. Educational initiatives should be tailored to the concerns of these important audiences. For this reason, a "language audit" should assess whether and how the language used in the field may contribute to negative attitudes. In addition, a clear description (or taxonomy) of substance abuse and dependence, and effective treatments for these conditions, should be created to provide a common reference point.

> **"ADDICTION IS AN EQUAL OPPORTUNITY DISEASE."**
>
> — *Advocate*

> "ESTABLISHING A PROGRAM THAT IS CULTURALLY SENSITIVE ENTAILS MORE THAN JUST TRANSLATING MATERIALS OR HIRING A COUNSELOR WHO SPEAKS THE LANGUAGE OF THE POPULATION."
>
> — *Public Hearing Testimony*

Perhaps the most effective means to change attitudes will be to provide ways for people in treatment or in recovery to participate in the public dialogue about substance abuse/dependence and treatment. The public hearings held as part of the NTP process over the past year furnish powerful examples of their eloquence. Individuals willing to come forward — often at considerable risk, due to the stigma they now face — should receive encouragement and support. In particular, the information and training some may need in order to participate most effectively in groups, meetings, and technical discussions should be provided. And new forums — such as the public hearings — could afford additional opportunities for people to contribute to solving problems. People in recovery will be the most eloquent voices and the most effective champions of treatment.

BUILD PARTNERSHIPS

Recommendations

- Encourage formation of effective groups that will: a) unite people with alcohol and/or drug problems, people in recovery, their families and friends, and b) support collaboration among State/local systems of care and services that are responsible for various dimensions of the problem.
- Create forums where government agencies and private organizations can collaborate.
- Establish a Partnership Support Program that provides financial and other support to collaborative projects and groups working on issues related to substance abuse treatment.
- Establish "partnership-building" as a priority objective in all appropriate programmatic and funding activities.

Suggested Action Steps

- Encourage and support community-based nonprofits to conduct regional public education conferences to create forums for working together on local substance abuse treatment goals.
- Continue to provide economic and technical support to local recovery groups.
- Provide funding and technical support to build the organizational capacity of grassroots groups comprised of people in recovery and family members, including such elements as materials, peer mentoring, training, networking opportunities, communications assistance, and conferences.

- Convene three consecutive national annual forums for people who are at-risk for, suffering from, or in recovery from alcohol and/or other drug abuse and those associated with them.
- Create tools, toolboxes, message and educational materials, and guidelines for grassroots efforts.

Discussion

Substance abuse and dependence affects individuals, families, workplaces, government budgets, public safety, company profits, and community well being. These recommendations are designed to stimulate and support the multiple collaborations that are essential to implementing the NTP. The focus is on creating opportunities for various groups and interests with a shared concern about treatment for substance abuse and dependence to learn about each other and how to work together, as well as to support that collaborative work. In particular, individuals with alcohol and drug problems, those in recovery, and their families, should be encouraged and enabled to participate in partnerships.

Most important is the creation of opportunities for people with alcohol and drug problems to help solve the problem. People in treatment and those in recovery are the most eloquent communicators about the value of treatment in their own lives. They can play an essential role in effective partnerships. However, many barriers limit their participation — including fear of stigma, travel costs, inability to take unpaid leave from work to participate, and need for skills development (see *Change Attitudes, above*).

Another essential element is to build partnerships between and among the varied systems with overlapping responsibility for individuals who may have substance abuse and dependence problems and their families. These partnerships can help all systems to fulfill their responsibilities more effectively, while assuring the best use of available resources (see *Invest for Results, No Wrong Door to Treatment, above*).

CSAT can provide essential support for these recommendations and lead efforts to build and support partnership development. Through its convening role and its ongoing relationships with many organizations, CSAT can conduct and provide support for a variety of activities that bring groups together to find common ground and address common goals. One important example is the agency's role in the proposed new Connecting Services and Research (CSR) system (see *Panel IV Report: Connecting Services and Research*). A further example would be the development of a research-practice-policy partnership. CSAT also can encourage the development of partnerships at the State, regional and local levels that can preserve the benefits of specialized, community-based services while enabling service organizations to attain the critical mass needed to support infrastructure improvement and quality management (see *Commit to Quality, above*).

The proposed Partnership Support Program suggests a model for CSAT and/or other funding organization to encourage and enable others to build partnerships. It should emphasize collaborations among groups with varying interests and priorities, and should recognize that an extended period of support may be necessary to build solid working relationships. It should be flexible enough to be responsive to opportunities, so as to encourage creativity among potential recipients of funds. Support should be available for a wide variety of activities, such as meetings, ongoing communication, task forces or forums on problems of shared concern, development of materials, web sites, and discussion groups. The program should target liaison and communication activities that are often considered ancillary and less vital than the production of tangible products. It should model collaboration by seeking joint funding opportunities whenever possible. Federal and State governments, foundations, or private organizations each may create such programs.

Many of the NTP recommendations will only work through collaboration among key partners such as:

- Single State Agencies for substance abuse;
- Providers and provider associations;
- Individuals with a history of alcohol or drug problems, and those in recovery;
- Families;
- CSAT, NIDA, and NIAAA; and
- Interested foundations.

At the same time, partnerships can and should involve many groups and organizations outside the field of alcohol and drug problems:

- Mayors and County officials;
- Governors, State, and Federal legislators, and staff;
- Tribal councils;
- Other Federal agencies;
- Educators and students;
- Professional associations;
- Employers and the business community;

- Payors and insurers;
- Labor unions; and
- Groups concerned about a wide variety of specific populations and issues including: women; children; mental health; managed care; primary healthcare; elderly; people with disabilities; racial, cultural and ethnic minorities, and particular population groups, such as Native Americans; HIV/AIDS; youth; child welfare; domestic violence; housing and homelessness; vocational rehabilitation; crime; highway safety; economic productivity; and the quality of healthcare.

Effective partnerships are based on shared priorities or specific objectives, rather than simply on general shared interests. For example, alcohol and drug treatment groups might work with justice groups and mayors on public safety; with public health agreement on HIV; with youth, education and suicide prevention groups on teen suicide; with business and labor groups on workforce health and productivity; and with medical associations on physician impairment.

Partnerships do not imply agreement on everything. It is important to identify and focus on areas of agreement to move forward. Starting points include the *National Drug Control Strategy* and *Healthy People 2010* (see *Introduction and Background*, above). Some useful themes with broad agreement might include "best use of resources" and "invest in what works" (see *Invest for Results*, above).

> **"IF WE REALLY WANT TO CHANGE THE CONVERSATION, THE FINAL PRODUCT OF THIS PROCESS SHOULD BE A DOCUMENT THAT CAN BE USED ... TO BUILD CONSENSUS AROUND THE COUNTRY."**
>
> *— State Provider Association Leader*

Partnerships grow stronger over time with growing familiarity and shared victories. These recommendations focus on ways to develop and support ongoing relationships through collaborative projects, forums, and various forms of communication. The success of the NTP ultimately will depend on engaging the commitment, participation and active support of many partners.

Like the previous guideline, this one is integral to all of the recommendations proposed in the NTP. Changing attitudes and involving partners form the foundation underlying the entire NTP.

CSAT's Next Steps

> *"At the end of this process of changing the conversation, the conversation needs to continue."*
> — *Executive Director of a State Substance Abuse Provider Association*

The NTP is an ongoing initiative. Initially CSAT will publicize the NTP across the nation through distribution to key audiences and the general public; systematic briefings of Federal agencies; and participation in conferences and community forums.

CSAT plans to focus initially on those recommendations for which CSAT already has both the authority and resources. Taken together, CSAT's implementation steps will be designed to promote a system that no matter where in the human services, health or justice systems an individual appears, his or her alcohol or drug problem will be appropriately identified, assessed, referred or treated.

Although the NTP is a major initiative, it has emerged from years of programs and research promoted by CSAT. CSAT is responsible for many diverse programs that focus on issues related to resources, communication, knowledge transfer, and training. Programs centered on the access to and effective direction of resources include, the Substance Abuse Prevention and Treatment Block Grant, the Targeted Capacity Expansion (TCE) and the Community Action Grant. Both the TCE and the Community Action Grant focus on providing organizations with resources to improve treatment. CSAT also focuses substantial resources on the effective use of industry knowledge and information, through programs such as the Practice/Research Collaborative, the Criminal Justice Treatment Networks and the HIV/AIDS Outreach program. These programs provide community outreach and promote effective knowledge transfer. The Recovery Community Support Program provides the recovery community with a vehicle to communicate perspectives and insights and increase public awareness of issues associated with stigma. CSAT also operates two organizations, the Addiction Technology Transfer Centers and the National Leadership Institute, that provide training and technical assistance throughout the field. Many of the resources available within these organizations can support the implementation of NTP recommendations.

CSAT will begin implementation by addressing the following 10 recommendations that reflect each of the guideline areas and each of the expert panel reports (see following page).

Recommendation	*Sources* *(Panel Report)*	*Guideline*
Develop a standard insurance benefit package.	I - Gap	***Invest for Results***
Develop reimbursement mechanisms aligned with treatment goals, incorporate performance measures and outcome standards, and ensure rates sufficient to cover both costs and a surplus to support reinvestment.	III - Systems	
Develop a taxonomy of services and treatment levels reflecting best practices in the field.	I - Gap III - Systems	*"No Wrong Door" to Treatment*
Develop the strategic plan for implementation of the Connecting Services and Research System (CSR).	IV - Services/ Research	***Commit to Quality***
Promote organizational cultures that improve the quality, effectiveness and efficiency of services through the adoption of best business practices for program management and operations.	III - Systems	
Develop a CSAT National Workforce Development Program to perform the action steps defined in the NTP panel's report.	V - Workforce	
Conduct a substance abuse language audit.	II - Stigma	*Change Attitudes*
Conduct science-based marketing research to provide the foundation for a social marketing plan.	II - Stigma	
Enter into formal memoranda of agreement with the appropriate Federal partners for the development and operation of the CSR.	IV - Services/ Research	***Build Partnerships (Commit to Quality)***
Define and support processes for cross-system consensus on: a) evidence-based treatment protocols and b) methods and measures for continuous monitoring of quality of care.	I - Gap	

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Glossary

Changing the Conversation about substance abuse will require reexamination of the language used to describe and discuss these issues. The individual panels differed in their use of language, providing a clear illustration of the need for the "language audit" recommended as an initial action step to change attitudes. For purposes of this report, the following definitions and terms were used.

SUBSTANCE ABUSE: This term describes a behavior, and not a condition, but it remains the most commonly used term to describe disorders involving the use of alcohol and illegal or regulated drugs. In general, in referring to substance abuse, we are referring to the use of any drug in a manner that deviates from the approved medical or social patterns within the culture. The terms alcoholism and drug dependence, substance abuse and dependence or substance abuse/dependence are used in preference to abuse. In each case, the definition intended is that in the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association.

PEOPLE WITH SUBSTANCE ABUSE PROBLEMS: Similarly, the terms people with alcoholism and drug abuse or dependence problems, persons with the disease or illness or addiction, or client are used wherever possible. Here, we are referring to individuals who meet diagnostic criteria for receiving treatment and whose symptoms have progressed to the point where they require intervention and treatment. This illness is often progressive, recurring and relapsing. The treatment may well have an acute phase, but a long term recovery plan is also needed, which may include ongoing support and follow-up as well as additional treatment for some. We also refer to persons with a history of alcohol or drug problems, to emphasize that even after successful treatment, individuals may face problems. In addition, the Report includes reference to the client's family, or family and friends wherever possible, to emphasize the scope of the impact of alcohol and drug abuse.

BIOPSYCHOSOCIAL DISORDER: The nature of the disorder is influenced by a combination of biological, medical, psychological, emotional, social, and environmental factors.

DIVERSITY: The variety reflected in the population, including differences in race, ethnicity, socioeconomic status, education, religion, geographic location, age, sexual orientation, disability, and gender.

EVIDENCE-BASED PRACTICES: Interventions and approaches supported empirically through systematic research and evaluation. These are to be distinguished from best practices, which are interventions and approaches more likely to yield desired results, based on indicative studies or judgment/consensus of experts.

TREATMENT: Refers to the broad range of primary and supportive services — including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychological services, and follow-up, provided for persons with alcohol and other drug problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or other drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse progress of associated problems (IOM, 1990a).

Changing the Conversation: Approach and Process

Creation of the NTP Initiative has included several important components: (1) leadership and oversight by senior members of the CSAT staff, members of the CSAT National Advisory Council, and a steering group that included senior members of the treatment field; (2) expert panels, involving both government and outside experts in the alcohol and drug treatment and allied fields; (3) public hearings and solicitation of experiences and ideas through written and online comments; and (4) a collaborative editorial process to assure that this report accurately expresses the essential message.

The NTP leadership group first selected five domains of concern to the substance abuse treatment field. These were intended to focus on key, persistent problem areas, while ensuring a comprehensive look at the field. An expert panel was selected for each domain. Recommendations for panel members were solicited from national organizations, members of the CSAT National Advisory Council, the steering group, senior CSAT staff, and other leading experts in the field. The selection attempted to assure a wide range of opinion and perspective, as well as representation of the rich geographic, ethnic, cultural, and disciplinary diversity that characterizes the issues and the field. Panel chairs were carefully chosen not only for their expertise, but for their skills in managing a group process designed to produce a consensus report. As noted previously, the panels started from and did not duplicate the foundation provided by previous reports, culling the best information, leading issues, implications, and recommendations that have been advanced in the field. Sources were identified by project staff, CSAT senior staff, and leading experts in the field. The domains, along with some of the initial questions posed, include:

CLOSING THE TREATMENT GAP (PANEL I)

Where are the gaps in treatment? How do populations and demographic characteristics, and treatment types and settings impact the treatment gap? How can we close the gap between substance abuse treatment and other related systems of care (e.g., mental health, health, welfare, child welfare, housing)? What are the policy, organization, and financing issues in the private and public systems, including Medicaid and Medicare that must be addressed in order to close the treatment gap?

REDUCING STIGMA AND CHANGING ATTITUDES (PANEL II)

Because this is the first systematic national effort to explore these issues for substance abuse treatment, what can CSAT, the treatment field, consumers and families do to address the negative attitudes toward addictions, treatment, and individuals with alcohol and drug problems?

IMPROVING AND STRENGTHENING TREATMENT SYSTEMS (PANEL III)

What are the clinical and organizational challenges facing treatment organizations in the public and private sectors? How can CSAT, the treatment field, consumers and families improve and strengthen treatment organizations so that they can adapt to the new imperatives of the changing treatment system? And to improve the relationship between the general healthcare system and the specialty substance abuse treatment system?

CONNECTING SERVICES AND RESEARCH (PANEL IV)

What are the best methods by which CSAT, the treatment field, consumers and families can foster and support evaluation of proven research findings in community-based settings and identification and adoption of best practices?

ADDRESSING WORKFORCE ISSUES (PANEL V)

What are the issues facing clinicians treating addictions? What can CSAT, the treatment field, consumers and families, and professional associations do to foster training, appropriate certification or other credentials, and licensure in all settings in which treatment occurs? And to support treatment organizations in developing appropriate policies for clinical training?

The domains overlapped to a considerable extent, making any particular division somewhat arbitrary. These overlaps provided an opportunity for the panels to exchange ideas on issues that crossed domain lines.

Each panel met four times between April 1999 and February 2000. Assisted by consultant staff, they reviewed previous studies, literature reviews and recommendations related to their domain, identified additional literature and reports, and developed an approach to the task of formulating recommendations. In addition to reviewing background materials, each panel invited speakers to address topics of particular concern. CSAT senior staff participated in each panel both as experts and to provide information about CSAT and other programs. Consultant staff worked with each panel and its chair(s) to organize the meetings, obtain needed information, and prepare the panel's report. An extensive comment and review process was undertaken to ensure that each report accurately reflects the deliberations and conclusions reached by the panel. Finally, representatives of each panel, as well as the steering group, participated in an editorial board to review the collective guidelines and recommendations presented in this report.

To build upon the panel's efforts, CSAT convened six public hearings throughout the Nation to ensure that community perspectives are incorporated in the NTP Initiative. The hearings were held in geographically diverse areas in order to receive testimonies, both oral and written, from a wide variety of individuals and organizations involved with and affected by alcohol and drug problems. Over 400 testimonies were heard from individuals from 31 States. Hearings took place in Arlington, VA; Hartford, CT; Chicago, IL; Portland, OR; Tampa, FL; and Washington, DC. Hearing summaries were placed on the NTP Website, where members of the public who could not attend hearings also had the opportunity to post comments. The panels received summaries of the testimonies presented in the public hearings throughout the process, to ensure that they could incorporate the views of testifiers as part of their deliberations, and many members of the panels attended one or more public hearings.

The full panel reports, summaries of each public hearing, and lists of participants are collected in a separate volume entitled *Changing the Conversation: Panel Reports, Public Hearings, and Participants.*

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DHHS Publication No. (SMA) 00-3480
NCADI Publication No. - BKD 383
Substance Abuse and Mental Health Services Administration
Printed 2000

CSAT
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IMPROVING SUBSTANCE ABUSE TREATMENT: THE NATIONAL TREATMENT PLAN INITIATIVE

Changing the **Conversation**

NOVEMBER 2000

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Improving Substance Abuse Treatment: The National Treatment Plan Initiative

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Panel Reports, Public Hearings, and Participant Acknowledgements

Changing the **Conversation**

NOVEMBER 2000

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Acknowledgements

The National Treatment Plan (NTP) Initiative is conducted under the general auspices of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and the CSAT National Advisory Council. At its meeting on May 12, 2000, the National Advisory Council formally recommended "*Changing the Conversation, Improving Substance Abuse Treatment: The National Treatment Plan Initiative,*" to CSAT for its consideration and implementation as appropriate.

NTP reports are developed under the supervision of Dr. H. Westley Clark, Director; Dr. Camille T. Barry, Deputy Director; Donna M. Cotter, NTP Coordinator; and Dr. Mady Chalk, Director, Office of Managed Care. This report is based on the detailed review and recommendations of five expert panels that were convened by CSAT, and that deliberated from April 1999 through February 2000, with assistance from numerous CSAT staff. Representatives of the five panels and a steering group of field leaders formed an editorial review board for the report. The Lewin Group, led by Leslie J. Scallet, Project Director, and Dianne S. Faup, Project Manager, provided staff support to CSAT and to the panels.

The opinions expressed herein are the views of the panel members and do not necessarily reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS).

Changing the **Conversation**

THE NATIONAL TREATMENT PLAN INITIATIVE

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Preface

The Center for Substance Abuse Treatment (CSAT) began the National Treatment Plan Initiative (NTP) in the fall of 1998, to provide an opportunity for the field to reach a working consensus on how best to improve substance abuse treatment, and then to pursue action to effect needed change. The NTP is not designed to create a traditional "national plan" to be published and cited. Rather, it was intended to provide a common starting point, to engage people throughout the field in a collaborative effort, and to recommend the types of guidelines and actions that over time can help to make effective substance abuse treatment available to all who need it.

Changing the Conversation is the first product of the NTP Initiative. It was developed through extensive examination of relevant research and past reports, consultation and discussion among experts reflecting a broad cross-section of opinion and experience throughout the field, and active solicitation of public comment. Expert panels met between April 1999 and February 2000. CSAT encouraged public comment through field publications and a dedicated web site, and convened public hearings from July through November 1999 to ensure that community perspectives were incorporated.

This volume, *Changing the Conversation: Panel Reports, Public Hearings, and Participants*, contains the full panel reports, summaries of the public hearings, and lists of all contributors. The companion volume, *Changing the Conversation: The National Treatment Plan Initiative to Improve Substance Abuse Treatment*, presents a set of guidelines and recommendations drawn from the work of the five (5) panels and the many additional individuals who participated in the hearings and submitted comments. It represents the collective vision of the participants in the NTP over the past eighteen months. The Substance Abuse and Mental Health Services Administration (SAMHSA), CSAT and the participants regard this as the beginning of a long-term effort that will engage the attention and energy of people throughout the country.

Section I: Panel Reports

Report of Panel I: Closing the Treatment Gap

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I. Executive Summary

Panel members focused on identifying ways to close the "gap" in alcohol and drug treatment, defined as the difference between individuals requiring treatment and those receiving treatment. This report discusses a number of underlying issues surrounding the treatment gap and proposed recommendations for filling the gap.

Substance abuse and dependence is a "biopsychosocial" disorder, which means that the nature of the disorder is influenced by a combination of biological, medical, psychological, emotional, social, and environmental factors. The disorder is progressive, chronic, and relapsing. Often, substance abuse dominates an individual's life, with a profoundly negative impact on the individual and those around him or her.

Substance abuse disorders afflict approximately 13 million individuals. Of those 13 million individuals, only about 3 million are receiving treatment, leaving approximately 10 million people stranded in the treatment gap. To fill this gap, the Panel strongly recommends a "no wrong door" strategy to assure effective and appropriate care for all individuals in need of treatment, regardless of demographic or other factors that might impede their access to care. The Panel considered approaches that would reflect the needs and concerns of all individuals who might use the substance abuse system or other overlapping systems. They sought to understand the factors that impact individuals and their families and friends.

Although it is now well established that treatment is effective to counter substance abuse, the Panel identified significant barriers to treatment: societal, organizational, and individual factors; access to appropriate treatment; the use and allocation of resources and adequate financing of programs and services; and issues surrounding the quality of care and treatment outcomes.

To address these barriers, the panel developed recommendations in three areas: Access and inter-State linkages; resource allocation and financing; and quality care and outcome measures.

ACCESS AND INTER-SYSTEM LINKAGES emphasizes the benefit of multiple systems working together to ensure that appropriate, effective care is available to all individuals in need of treatment.

1. **Develop a plan to create a nationwide expectation for alcohol and drug treatment such that no matter where in the human services, health, or justice system an individual appears, his or her alcohol or drug problem will be appropriately identified, assessed, referred, or treated.**

RESOURCE ALLOCATION AND FINANCING focuses on improving public and private insurance benefit packages, increasing the resources in the system, and using system resources more effectively.

2. Increase total resources available for substance abuse treatment (i.e., Federal, State, local, and private) in order to reduce associated health, economic, and social costs.

3. Develop a standard insurance benefit for substance abuse treatment that provides for a full continuum of appropriate and continuing care to meet the needs of persons with substance abuse disorders.

4. Provide sustained support to increase State and local capacity to identify, assess, determine, and monitor need for treatment at the local/community level.

5. Organizations and payors that want to engage in delivery of services for substance abuse screening, assessment, and/or treatment should: (1) use evidence-based treatment protocols; and (2) continuously monitor quality of care (structure, process, and/or outcomes) using common methods and measures adopted by the field through a consensual process. This should apply to both public and private providers and payors, operating in the substance abuse, primary health, social service/welfare, justice, education, or other fields.

QUALITY CARE AND OUTCOMES MEASURES centers on improving the quality and appropriateness of care provided and creating an ongoing monitoring process for maintaining a high level of care.

6. Define and help support processes to reach cross-system consensus on evidence-based standards for quality of care and practices that apply to all systems and payors.

7. Facilitate cross-system consensus on critical data elements to measure quality of care and treatment outcomes.

Viewed collectively, these recommendations provide the strategic base to ensure that those in need of treatment actually receive treatment, that sufficient public and private resources are available and appropriately employed to deliver the "quantity" (frequency, duration, intensity) of treatment, and that the types and levels of care needed are available.

II. Defining the Treatment Gap

Substance abuse and dependence is a complex disorder, with associated biological, psychological, and social causes and effects. Historically, this disorder has been treated as a social problem while the psychological and biologic aspects largely have been ignored. However, the deterioration of functionality within each of these aspects of the disorder requires that treatment and intervention address the entire biopsychosocial continuum. In addition, substance abuse and dependence is a chronic, relapsing illness. Although many of the symptoms and associated illnesses require that a client receive specialized or acute care, these systems might not be prepared to treat the chronic elements of the illness.

In this report, people with alcohol and drug abuse disorders are defined as individuals who meet diagnostic criteria for receiving treatment whether the nature of their presenting symptoms is biological, social, or psychological. These individuals have progressed to the point where they require intervention and treatment. However, given the social aspects of this disorder, the ramifications and possibly the causes of substance abuse extend beyond the individual experiencing the problem to affect those around him or her, as well. Thus, it is also important to address the treatment needs of family and friends closely affected by this disorder.

Many organizations and agencies have published estimates of the number of people experiencing problems with drugs and/or alcohol in the United States. Across studies, the findings consistently demonstrate that there are more individuals in need of treatment than can be accommodated by the system. In most reports, alcohol and drug abuse are studied separately. The Office of National Drug Control Policy (ONDCP) focuses on drug problems, and many of its findings are cited in this report. The National Institute of Health (NIH) focuses on alcohol and drug abuse in two separate institutes, the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The separate statistical representation of alcohol and drug use means that attempts to combine the numbers provide only rough estimates because double counting may occur. The fact is that approximately half of people with drug problems also suffer from alcohol disorders. The disparity in survey methodologies and access to data also produces many of the numeric differences. Nonetheless, the numbers presented below paint a broad picture of the size of the treatment gap.

According to the ONDCP's *1999 National Drug Control Strategy*, there are approximately 4 million chronic drug users in the United States. This closely aligns with the *1998 National Household Survey on Drug Abuse*, which found that 4.1 million people were in need of drug treatment. The NIAAA report, *Improving the Delivery of Alcohol Treatment and Prevention Services*, estimates that there are 14 million alcohol abusers, whereas the *1998 National Household Survey on Drug Abuse* finds approximately 9.7 million people in need of alcohol treatment. Regardless of the source, a conservative estimate of those in need of substance abuse treatment is between 13 and 16 million people. In contrast, both the 1997 Institute of Medicine (IOM) report, *Managing Managed Care*, and the 1998 *National Household Survey* conclude that approximately 3 million people receive care for alcohol or drugs in one year. Although, as previously stated, neither the estimates of those in need nor the estimates of those in treatment are all inclusive, the picture remains the same — more than 10 million people who need treatment each year are not receiving it.

To move toward closing the treatment gap, a clear understanding of how treatment is defined is necessary. Panel members agreed that for this report, treatment would be defined as follows:

> *"Treatment refers to the broad range of [primary and supportive] services — including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services, and follow-up, provided for persons with alcohol [and/or other drug] problems. The overall goal of treatment is to reduce or eliminate the use of alcohol [and/or other drugs] as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems" (IOM, 1990a).*

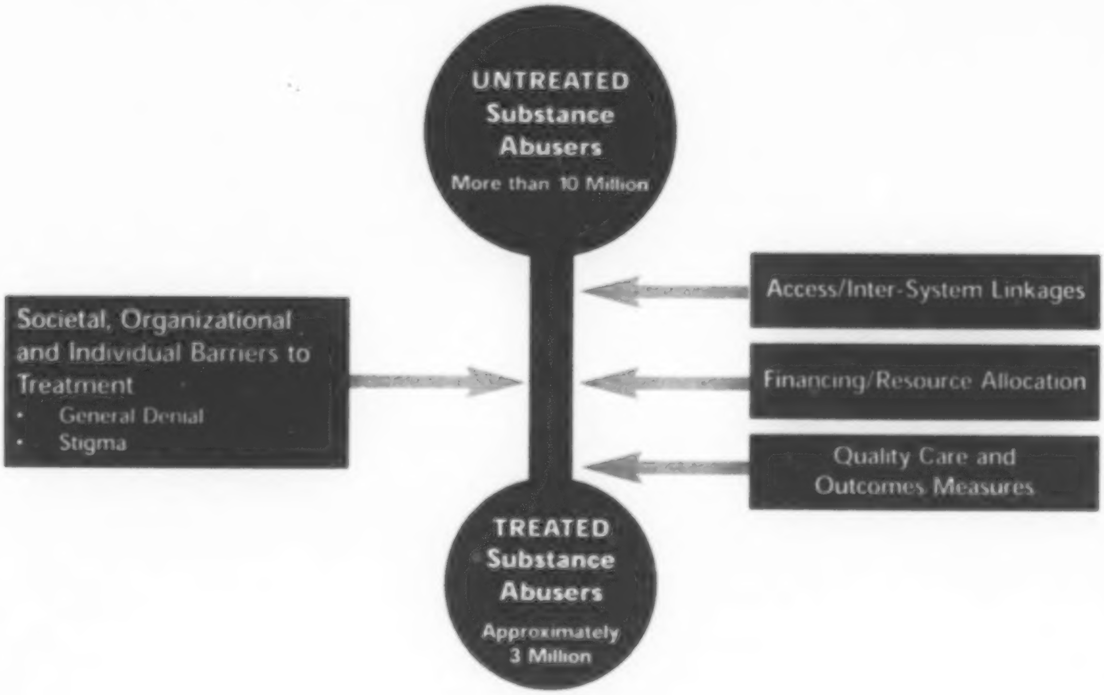
It is becoming increasingly evident that treatment is effective in addressing substance abuse. For example, the ONDCP 1995 National Drug Control Strategy stated that "studies and statistics indicate that the fastest and most cost effective way to reduce the demand for illicit drugs is to treat chronic hard core drug users." The ONDCP used this empirical evidence to buttress its plan for more effective use of available Federal treatment grant funds to move individuals into treatment and the increased use of justice system resources to treat chronic users under their authority. Other studies have also supported this view.

> *"Research has shown that drug abuse treatment is both effective and cost effective in reducing not only drug consumption but also the associated health and social consequences. . . . Treatment gains are typically found in reduced intravenous and other drug use, reduced criminality, and enhanced health and productivity" (IOM, 1996).*

III. Understanding the Problem

The next step is to understand what factors are contributing to the gap and interfering with effective treatment. The Panel separated the treatment gap into four main discussion areas: Societal, Organizational, and Individual Barriers to Treatment; Access and Inter-System Linkages; Financing/Resource Allocation; and Quality Care and Outcomes Measures (see Figure I.1).

Figure I.1 Major Access Barriers in Substance Abuse Treatment


UNTREATED Substance Abusers
More than 10 Million
Access/Inter-System Linkages
Societal, Organizational and Individual Barriers to Treatment
• General Denial
• Stigma
Financing/Resource Allocation
Quality Care and Outcomes Measures
TREATED Substance Abusers
Approximately 3 Million

A. SOCIETAL, ORGANIZATIONAL, AND INDIVIDUAL BARRIERS TO TREATMENT

There are many reasons why individuals fail to get treatment, including stigma associated with the disorder; cost of treatment; unavailability of support services, such as child-care or transportation; and failure of systems to effectively identify individuals and direct them into treatment.

These issues intensify for individuals categorized as "special" populations. The treatment system often does not provide well for population groups such as women, children and adolescents, the aging and disabled, ethnic groups, and rural populations. Historically, programs have been aimed at men; thus, there are a limited number of women- or juvenile-oriented programs. Because access issues due to pregnancy and child-care are prevalent within these groups, the result is impaired access to care. Gender and age are not the only barriers; ethnic and racial differences frequently prevent individuals from accessing treatment due to language or other cultural barriers.

Furthermore, geography poses a problem in many rural areas because an insufficient number of programs are spread across different regions. These scattered programs pose problems for accessibility (e.g., long travel times or lack of transportation), especially for individuals in need of on-going care. Location of care, type of care available, hours of operation, and other program characteristics often limit client access to care. In addition to these barriers, some individuals who have access to treatment do not choose to use it. Many people fail to accept the magnitude of their specific problem, or have a fear of the public perception associated with treatment. Their "denial" increases the importance of rigorous screening across systems and facilitating access to treatment for resistant individuals.

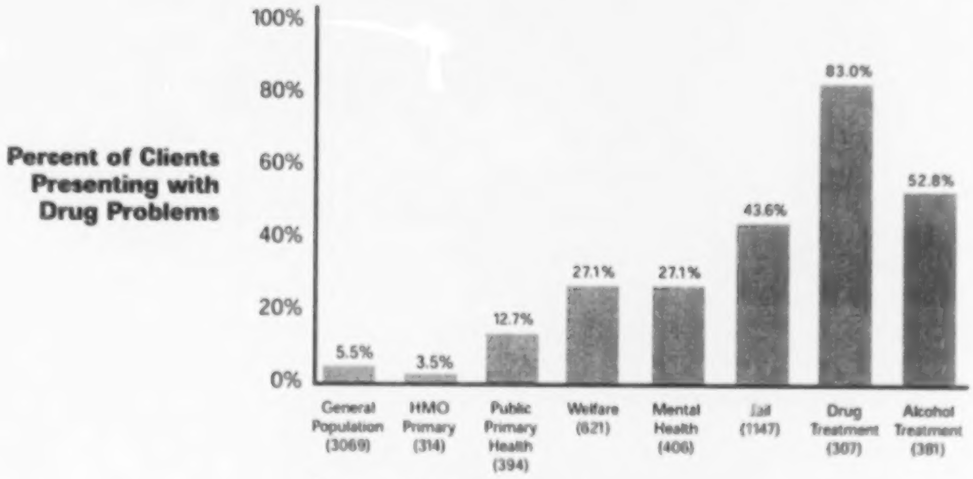
B. ACCESS AND INTER-SYSTEM LINKAGES

Because of the nature of the disorder, individuals in need of treatment might appear in various settings, including healthcare, the justice system, mental health, welfare and social services, and juvenile or educational systems. Often they are not effectively screened and diagnosed to facilitate movement into treatment. Different systems function independently, often failing to use inter-system linkages that could increase the number of individuals able to receive treatment as well as the resources available for treatment.

Additionally, the lack of cohesive interaction among systems interferes with the ability of the treatment system to provide a high quality continuum of care. The disconnection between overlapping systems does not foster effective identification and maximization of the resources (financial or otherwise) available across systems. The development of an interactive system that matches care to need, regardless of point of entry, is crucial to establishing inter-system linkages and improving success.

A recent study (Weisner, 1999) of new admissions of weekly drug users across population and community agency systems shows the prevalence of drug users located in other systems (see Figure I.2).

Figure I.2 Distribution of Drug Users Across Health, Social Service, Justice, and Other Sectors of the Community



Source: Weisner (1999)

The justice system poses one of the greatest challenges for improving access. One study estimates that approximately 1.4 million or 80 percent of the people who are incarcerated have a history of alcohol and/or drug abuse (Culpepper Foundation, 1998). Furthermore, many of the incarcerated individuals who are in need of treatment do not have access to treatment. A report from Join Together (1996) indicates that only seven percent to15 percent of incarcerated persons receive treatment. Additionally, the problem extends beyond the walls of the correctional facility. Substance abuse is equally a problem among juvenile justice populations and parole and probation populations and can also be an issue in civil proceedings. In a 1995 survey of adults on probation, nearly 70 percent reported past drug use, and 32 percent admitted to illegal drug use in the month before their arrest (Bureau of Justice Statistics, 1997).

Inability to effectively deal with persons in need of treatment is not limited to the justice system. For instance, studies show that primary and urgent care physicians treat a substantial number of individuals in need of substance abuse treatment (Join Together, 1998). Often health care providers are unable to identify the treatment needs of their patients and are not linked into the appropriate system to effectively guide patients into treatment.

The inter-system disconnect is also common between the mental health and substance abuse treatment systems. A joint report by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) indicates that there are 10 million persons with at least one co-occurring mental health and substance abuse-related disorder. Patients with mental, drug, or alcohol disorders appear in both systems and often are missed or misdiagnosed (NASMHPD and NASADAD, 1999). Additionally, differences in insurance coverage and differences in funding mechanisms between systems fuel the disconnect between systems because diagnoses might not be covered from one payor to another.

There is also a substantial disconnect between the social service system and the substance abuse treatment system. In the welfare system, caseworkers have limited clinical training and few standards for screening and assessing individuals who might be in need of treatment. This lack of training makes it difficult to identify patients who are in need of treatment, and nearly impossible to ensure that they are referred into treatment (IOM, 1997a; National Association of Alcohol and Drug Abuse Counselors [NAADAC], 1998).

Inter-system issues that contribute to the treatment gap are not limited to the inability of systems to identify and move individuals toward appropriate treatment. They also include the difficulty associated with transferring patient-specific information from one system to another. For systems to interface effectively, they must share relevant data. Currently systems with overlapping clients often do not exchange data. These systems frequently lack updated information systems, standard reporting requirements, and consistent and clear communication processes. The lack of collaboration and communication between systems can be attributed to the territorial nature of some agencies and systems, whereas in other cases, conflicting or different organizational missions make collaboration, even for the greater good, more difficult.

Another challenge associated with the effects of substance abuse that systems must address is the impact of the problem on those not directly involved. Treatment tends to focus on the individual experiencing problems and not on the families, friends, and others affected by the disorder who are not actively involved in substance abuse. The Panel believes that the ability to work with children and family members of the client is critical and must be considered by all systems interacting with persons experiencing problems with alcohol or other drugs.

C. RESOURCE ALLOCATION AND FINANCING

Resources as defined in this context include the financial, infrastructure, and other resources that support and sustain the provision of substance abuse treatment. The adequacy of resources addresses the amount of resources currently available in the system, and the effective use of resources addresses the ability to use and deliver better results with limited funds. These financing and resource allocation issues directly determine the ability of an individual to access treatment.

Despite the many factors that contribute to the gap, the Panel agrees with many in the field that inadequate funding for substance abuse treatment is a major part of the problem. Over the last decade, spending on substance abuse prevention and treatment has increased, albeit more slowly than overall health spending, to an estimated annual total of $12.6 billion in 1996 (McKusick, Mark, King, Harwood, Buck, Dilonardo, and Genuardi, 1998). Of this amount, public spending is estimated at $7.6 billion (McKusick, et al., 1998). The public spending includes dollars from Medicaid and Medicare, as well as other Federal funds from the Department of Defense, the Department of Veterans Administration, the Department of Justice, and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant provides Federal support to addiction prevention and treatment services nationally through State and local governments. Private spending includes individual out-of-pocket payment, insurance, and other nonpublic sources, and is estimated at $4.7 billion (McKusick, et al., 1998).

One of the main reasons for the higher outlay in public spending is the frequently limited coverage of substance abuse treatment by private insurers. Although "70 percent of drug users are employed and most have private health insurance, 20 percent of public treatment funds were spent on people with private health insurance in 1993, due to limitations on their policy" (ONDCP, 1999b). In the view of the Panel, private insurers should serve as the primary source of coverage, with public insurance serving as the safety net.

Despite the $12.6 billion spent on substance abuse treatment, the system possesses limited resources. Several issues have an impact on the effective allocation of resources. Because financing is not based on the effectiveness of programs, inefficient allocation and use of resources is common. Clients often enter treatment based on the geographic and financial factors that affect their ability to access care. An individual's course of treatment frequently is decided based on the program to which he or she has access rather than on his or her specific needs. Often a patient's gender, culture, or other individual factors are not considered in the treatment plan. Thus, the needs of special populations such as women, children, and minorities who require additional or different services might not be addressed.

Not only are treatment resources limited, but eligibility requirements associated with different Federal funding streams are often inconsistent, making funding somewhat inflexible. The Panel believes that the stringency of these requirements enables ineffective methods for allocating resources.

The Institution for Mental Disease (IMD) exclusion in Medicaid can be one such hindrance to treatment. The IMD exclusion, unless otherwise amended by a waiver, prohibits inpatient or residential settings with more than 16 beds from using Medicaid dollars to cover that care. Through statutory language and regulations promulgated by the Health Care Financing Administration (HCFA), no residential facility that has more than 16 beds may receive reimbursement for alcohol and drug treatment. However, effective financing and treatment for substance abuse and dependence requires the flexibility to use residential care when needed.

Other issues related to resources that are affecting the treatment system — such as low resources relative to the number of clients treated, low wages, erosion of dollars per client, staff burnout, and other provider issues — make it difficult to provide a full continuum of appropriate care. Further exacerbating the gap is the poor condition of many structural facilities and the lack of resources available to maintain or improve existing facilities or to build new ones (see Panel III Report).

D. QUALITY CARE AND OUTCOMES MEASURES

Substance abuse treatment lacks generally accepted standards of care and quality improvement protocols. Because care is frequently defined differently across different payors and providers, the care provided might vary for the same diagnosis, making some courses of treatment ineffective. This variation is compounded by cost reduction strategies of third-party payors that might affect clinical decisions and drive treatment decisions. This situation often leads to the provision of care that does not match the specific needs of the individual, and results in less effective treatment.

The lack of basic standards can also result in overuse and underuse of treatment. The Panel believes that specific areas without generally accepted standards include screening and assessment and quality assurance. In a system in which the point of entry determines the type of treatment received, the result of inconsistent screening and assessment approaches can be treatment that does not meet individual needs. To provide effective care, the standards must be structured so that providers can identify the level of care necessary and match it with the correct provider possessing both the resources and availability to treat the individual at the appropriate level of care. Currently the system does not require a set of standards across all types of providers within the system; until that is the norm, system inefficiencies that result in lower quality of care will persist.

In many cases, people experiencing problems with alcohol and/or drugs do not have access to the appropriate level of care, and the care they do receive may fall short of their needs. A continuum of care should include prevention, intervention, assessment, treatment, and maintenance. The general unavailability of an adequate continuum of care is evident in the limited funding available for brief interventions, where the purpose is to screen and provide quick therapeutic interventions. Further, the full continuum of care should include services needed by families and others affected by an individual's substance abuse disorder.

IV. Themes from the Public Hearings

To ensure the incorporation of community perspectives in this effort, the Center for Substance Abuse Treatment (CSAT) held six public hearings across the nation. More than 400 testimonies were heard from individuals from 31 States and included representatives from the recovery community, State and local agencies, treatment providers, educators, and researchers.

Considerable testimony was presented around the need for an increase in funding to support the improvement of treatment. These areas included: (1) services to individuals with co-occurring disorders, (2) treatment facilities (e.g., residential, long-term, women, youth, and hearing impaired settings), and (3) wraparound services for clients and their families (e.g., education programs, independent living skills, vocational training). Additionally, the need for integration with other systems such as primary care, child welfare, justice, and social services was often identified as critical.

Other testimonies expressed a need for:

- The development of a continuum of care;
- Parity for substance abuse treatment services;
- The system to be better equipped to address the diverse needs of its clients; and
- The consideration of treatment as an alternative to incarceration for non-violent offenders.

Panel members used the issues raised during the public hearings both to guide and to supplement their areas of discussion.

V. Recommendations

To address these problems, Panel members developed a series of recommendations focusing on three areas: inter-system relationships, resource allocation, and quality care and outcome measures.

A. ACCESS AND INTER-SYSTEM LINKAGES

1. **Develop a plan to create a nationwide expectation for alcohol and drug treatment such that no matter where in the human services, health, or justice system an individual appears, his or her alcohol or drug problem will be appropriately identified, assessed, referred, or treated.**

This recommendation calls for a "no wrong door" approach to effective treatment. It requires that there be access to treatment through all systems, regardless of point of entry, and that any treatment provided meets specific standards of quality. Due to the nature of substance abuse disorders, individuals may present in many different venues. The goal for each system is to be able to refer clients or provide effective treatment. Development of inter-system collaboration to maximize available services and resources is critical to provision of effective treatment. Because it is impossible for all systems to provide comprehensive effective treatment services, creation of integrated identification, screening, referral, and care management processes is essential to successful treatment outcomes.

Panel members believe that there are three main strategies for the implementation of this recommendation: (1) CSAT should serve as the lead agency for developing the plan; (2) CSAT should support the development of standards for treatment for those agencies outside the substance abuse treatment system, provide technical assistance, facilitate intergovernmental links, and coordinate with the ONDCP and the Substance Abuse and Mental Health Services Administration (SAMHSA) to promote implementation; and (3) protocols for providing evidence-based treatment may be attached to State and local funding streams to ensure effective treatment, regardless of point of entry.

Discussion

The negative impact that substance abuse has on health, crime, employment, education, and every other facet of life speaks directly to the benefits of providing treatment to those experiencing problems with alcohol or drugs. Treatment has been shown, among other things, to significantly lower drug and alcohol use, lower healthcare costs, reduce crime, and increase productivity. Thus, ensuring that the client experiencing problems with alcohol or other drugs receives treatment will help that individual recover from his or her disorder and also produce results for all of these systems.

The concept of maximizing access to allow for the effective provision of substance abuse treatment is not new. The Panel reviewed a wide variety of reports and studies that emphasize the importance of cross-system cooperation, and recognized that some progress has been made. Over the past several years, drug courts, health systems, schools, and social services programs have worked with the substance abuse system to place individuals in treatment. However, the Panel found that efforts have not been enough to overcome the competing forces that hinder access. For that reason, the Panel recommends a specific plan and shared standards of treatment.

The Panel strongly believes that to assist individuals in entering effective treatment, all systems must share a common approach to identifying the problem, assessing the nature of the problem, and determining the most appropriate treatment. To determine the most appropriate treatment plan, it is crucial that individuals conducting the screening understand the wide spectrum of options available. For this to happen, information must flow across systems.

For the no wrong door approach to be effective, each system must assume an appropriate level of responsibility for individuals or patients experiencing problems with alcohol or other drugs. These systems must ensure that their clients have access to and receive treatment. This requires that providers in systems interfacing with substance abuse problems be trained, at a minimum, in the identification of those in need of treatment. Because not all systems are able to provide treatment, there should be explicit limits on what each system is expected to do with regard to substance abuse treatment. These expectations should not exceed the responsibilities of each system; however, there should be an expectation that other systems will serve as a bridge to move clients from their agency to the substance abuse treatment system, when necessary.

At a minimum, all systems providing services to people experiencing problems with alcohol or other drugs should be able identify these problems; however, some systems can and should directly provide some level of treatment. The effectiveness of this treatment is paramount; thus, treatment must be held to specific standards, regardless of whether that treatment occurs within the specialty treatment system or outside it. Standards for effective treatment are discussed further in Recommendation Six.

A number of past recommendations have focused on specific systems that overlap with the treatment system. For example, a Join Together panel found that "a significant factor in ensuring access to substance abuse treatment is its integration into health and mental health care systems. Screening for, assessing, and intervening in substance abuse should be part of general medical and mental health practice" (1998). The IOM has called for the integration of primary care, mental health, and substance abuse treatment systems (IOM, 1996).

> *"Primary care and the alcohol and drug treatment systems have distinct areas of expertise, and better linkage and integration are desirable. It is important to recognize that treatment for alcohol and drug abuse is, in itself, a cost-containment measure, since early prevention in alcohol and drug problems may prevent the need for treating more costly medical complications. . . . NAADAC now recommends that alcoholism and drug addiction treatment be fully recognized and integrated into the medical, healthcare and public health systems" (NAADAC, 1999).*

The large number of people who suffer from co-occurring disorders, substance abuse/dependence, and mental illness creates a need for coordination between these treatment systems, which should range from informal consultation to formal collaboration to service integration, depending on severity of illness (NASMHPD and NASADAD, 1999).

As noted above, the justice system poses a significant inter-system issue for the substance abuse treatment system, and several reports advocate expansion of comprehensive drug and alcohol treatment for individuals who are incarcerated (Legal Action Center, 1993; American Society of Addiction Medicine [ASAM], 1994).

Several reports have recommended that overlapping systems share information to ensure comprehensive care. For example, the Department of Health and Human Services (DHHS) called for a lead agency, such as an "interagency coordinating body" to take responsibility for linking human services providers together, and later expanded the recommendation to include the sharing of information on values and perspectives by providers in overlapping systems to collaborate effectively (DHHS, 1991, 1996).

B. RESOURCE ALLOCATION AND FINANCING

2. **Increase total resources available for substance abuse treatment (i.e., Federal, State, local, and private) to reduce associated health, economic, and social costs.**

The goal of the treatment plan must include the more effective allocation of current resources as well as new resources to make more effective treatment accessible to a larger number of people who experience and are affected by problems with alcohol or drugs. The Panel feels strongly that the substance abuse treatment system does not currently possess sufficient resources to provide effective treatment for all who need and seek treatment and, therefore, strongly recommends that additional resources be put into the system. The recommendation charges Federal, State, and private entities with seeking additional resources from new sources and more efficiently using existing resources through the redefinition of funding boundaries.

To implement this recommendation, additional funding mechanisms must be sought, or existing resources must be made more readily available. This will require looking to government funds not usually tapped for substance abuse treatment, to private sources, and across systems to access additional financial resources. To maximize the use of current funding streams, additional flexibility is critical so that resources can be used across different social service systems to meet treatment needs. For example, by increasing the benefits provided in the private sector (see previous recommendation) through parity and comprehensive coverage packages, the financial burden on public programs might be alleviated, making more resources for medically indigent patients available within the public system. However, the Panel notes the importance of assuring that an increase in resources in one sector is not followed by a decrease in resources in another; otherwise, the need for additional resources will never be met.

One of the major problems with financing care is that the restrictions and inconsistencies existing across systems and programs hinder the effective use of resources. Various systems have different eligibility requirements as well as multiple approaches for serving certain populations; this often results in the provision of inconsistent types and levels of care. The IMD exclusion is a leading example of how the restrictions associated with funding streams can create barriers to treatment. It is important to note that the eligibility requirements, which make funding streams rigid, were developed primarily to counteract the inadequacy of care available for particular populations. Thus, providing adequate care for all populations will eliminate the need for such requirements. Decreasing resources and improving allocation can achieve the goal of increasing the flexibility of funding streams, expanding resources for treatment and providing more effective treatment to more people.

Discussion

This recommendation is based on clear evidence that substance abuse treatment contributes to recovery, helping individuals to improve health outcomes and reduce alcohol and drug use and other undesirable activities. As a result of treatment, there are significant economic benefits to communities, employers, and the patients, and their families. Prior recommendations have advocated increasing Block Grant resources to bolster the substance abuse treatment system, reallocating funds from interdiction and incarceration to treatment programs for justice populations, and increasing excise taxes for alcohol and tobacco. An IOM panel recommended an expansion of the public tier and suggested focusing additional resources on increasing capacity and improving the quality of services, facilities, and staff skills (ASAM, 1995; IOM, 1990b; Join Together, 1993; Legal Action Center, 1993; NAADAC, 1986).

> *"The balance of resources devoted to combating these problems should be shifted from a predominance of law enforcement to a greater emphasis on treatment and prevention programs, as well as programs to ameliorate those social factors that exacerbate drug dependence and its related problems" (ASAM, 1994).*

The Panel identified the need for additional resources to bolster the treatment system but did not specifically recommend the sources. There was consensus, however, that other systems must also assume responsibility for funding, that there exist other funding streams that can be tapped to enrich the service delivery mechanism either for direct clinical services or other associated services. Therefore, this recommendation targets those systems that interface with substance abuse treatment in addition to entities and stakeholders who can best determine how to increase resources and make them more flexible. These include legislators, third-party payors, State agencies, and community-based organizations dealing with multiple funding streams. CSAT may work toward the goal of this recommendation by using the Block Grant mechanism to make funding more coordinated and flexible. It is important to note that for systems to benefit from flexible funding streams, different systems must collaborate and be accountable for identifying and providing treatment to clients with substance abuse problems.

3. **Develop a standard insurance benefit for substance abuse treatment that provides for a full continuum of appropriate and continuing care to meet the needs of persons with substance abuse disorders.**

The Panel recommends establishing comprehensive benefit packages to move toward closing the treatment gap. The concept of parity, although not explicitly stated, is encompassed in this recommendation. Parity is the equal treatment by insurers and other payors of substance abuse treatment in a manner that is consistent with the treatment of other medical conditions. Equal treatment with other medical conditions is critical to the success of a mandated comprehensive insurance benefit package. The goal of this recommendation is to establish a comprehensive insurance benefit on par with benefits for other chronic illnesses, thus allowing for a full continuum of care.

Discussion

Current insurance benefit packages, both public and private, typically do not adequately cover substance abuse treatment. Many private and public (Medicaid and Medicare) insurance packages do not cover specific services, are for a limited number of units of service with annual or lifetime caps, or support limited or no continuing care. Further, the private sector takes no responsibility for those who cannot afford treatment when insurance coverage is exhausted, forcing the use of public funds for individuals with private insurance. Public resources, such as Medicaid and State substance abuse treatment systems that were originally intended to serve as a safety net, instead have become the primary insurance option for many individuals in need of treatment. Additionally, government insurance packages (specifically Medicaid) generally do not provide comprehensive treatment. For example, under the IMD Exclusion criteria, people experiencing alcohol or other drug problems may not be treated in a residential or inpatient setting with more than 16 beds. Such limited and often inconsistent coverage leads to inappropriate and insufficient care with less than positive outcomes.

The standard benefit endorsed by this recommendation is also aimed at ensuring coverage based on treatment needs rather than on economic feasibility. The Panel feels that given a certain diagnosis, there is an ethical responsibility to ensure that the client is offered services accordingly. Specifically, the provision of services should be based on clinical appropriateness and not on the allowances of an insurance plan. Furthermore, the standard benefit should be designed such that there is no conflict between the clinically appropriate strategy and the allowances of the insurance plan.

Implementation of this recommendation will address inappropriate cost shifting that now occurs between the private and public sectors in the substance abuse treatment system, eroding the quality of care and effectiveness of treatment. This proposal will create a system where the private and public sectors work collectively to ensure that all individuals receive appropriate comprehensive care. By providing coverage for a full continuum of care, standard insurance benefits will allow people experiencing problems with alcohol or drugs to gain access to the appropriate level of care and continuing care as they progress through treatment.

NIDA recently developed a guide, *Principles of Drug Addiction Treatment*, that lists 13 principles of effective treatment, including the necessity of multiple episodes of care, readily available treatment, treatment matched to individual needs, treatment of adequate length, and treatment that addresses multiple needs, not just drug use. These and the other principles in this guide must be considered in the development of a standard insurance package designed to ensure access to a full continuum of care.

Several IOM committees have made previous recommendations regarding insurance coverage for substance abuse treatment. Parity between coverage for substance abuse and dependence and other illnesses has been the focus of many of these recommendations (IOM, 1990a, 1990b). However, recommendations have also focused on coverage for the full continuum of care, mandating employer investment in benefit packages that include coverage for behavioral health problems, monitoring private insurers and managed care plans, and altering Medicaid to address substance abuse treatment needs (IOM, 1990b, 1996, 1997b). Panels convened by many other organizations have recommended parity coverage that better coordinates public and private resources (ASAM, 1992; Join Together, 1993, 1998; NAADAC, 1988, 1999).

The Panel suggests that CSAT should work with others to facilitate the implementation of this recommendation. For the recommendation to be successful, treatment professionals and organizations, such as the Health Insurance Association of America (HIAA), HCFA, and other third-party payors, must work together and promote the improvement of coverage options. In addition, the Block Grant and the provision of other funds from the Federal government should have the input of family members and people in recovery to better serve people experiencing problems with alcohol or other drugs. CSAT should facilitate efforts by the recovery community and other organizations to develop a standard benefit that is complete and outlines a full continuum of care.

4. **Provide sustained support to increase State and local capacity to identify, assess, determine, and monitor need for treatment at the local/community level.**

The Panel supports the devolution of planning for treatment from Federal to State and local levels to enhance State and local capacity to conduct planning, surveillance, and resource allocation to meet the specific needs of a geographic region. Although treatment need can be assessed most effectively at State or local levels, states and localities often lack the necessary resources to monitor treatment need and subsequently treatment services. As a result, people experiencing problems with alcohol or drugs cannot gain access to appropriate care because their community is not sufficiently equipped to meet the treatment needs of its residents. The ultimate goal of this recommendation is to combat this phenomenon by providing sustained support to monitor treatment need.

Discussion

Currently CSAT is shifting funding from the State Needs Assessment Program to use of the National Household Survey on Drug Abuse (NHSDA), which has become more comprehensive. The idea is that the data from the NHSDA can be used to help determine the level of funding for substance abuse treatment that should be allocated to each State. However, the Panel believes such data allow only for comparisons between States and do not provide enough information to assess treatment need to better allocate resources at the State, community, or local levels. To this end, States will continue to need support for determining treatment need within their borders.

Panelists also believe that it is important to examine the data currently being collected. Such data collection should be based on scientifically valid sampling and collection techniques to obtain a better picture of community need. The current markers of substance abuse and treatment need must also be expanded. Typically, the level of substance abuse-related crime is seen as the primary indicator of substance abuse; however, there are many health consequences of substance abuse that also indicate prevalence and need for treatment. Prevalence of hepatitis, HIV, cirrhosis, and other associated illnesses must be treated as markers of substance abuse and treatment need.

Previous recommendations primarily have addressed the means by which communities might better assess and meet residents' treatment needs. In 1990, an IOM panel suggested adopting common prevalence indicators to assess treatment need across geographic areas; expanding support of health services research programs that currently investigate financing policy issues to provide sufficient data for resource allocation; and establishing and funding a full continuum of care in all communities (IOM, 1990a).

This IOM panel concluded that, with a minimal level of funding, research committees could provide the necessary data for planners and policymakers to use in the decision-making process for allocation of resources and choices among competing modalities and settings. They further suggested that State agencies be required to submit plans that analyze the conjunctions and mismatches among the most current epidemiological information and known treatment capabilities; it also recommended that States be required to propose annual spending patterns that reflect this information (IOM, 1990a).

The Robert Wood Johnson Foundation's report, *Fighting Back Initiatives*, provides an excellent example of potential impact and benefits of community surveillance. In this initiative, a total of 14 communities engaged (or are currently engaging) in an effort to address substance abuse problems through a coordinated effort between public, private, and volunteer organizations. These communities work to identify and monitor indicators of substance abuse to reduce alcohol and drug abuse and associated effects.

Certain data are important to make sound policy decisions. States and localities do not have the resources to obtain and analyze data to accurately assess treatment needs and allocate resources accordingly. To obtain these data, the Panel suggests collaborative funding through a partnership among the ONDCP, the Centers for Disease Control (CDC), NIDA, NIAAA, and CSAT.

5. **Organizations and payors that want to engage in delivery of services for substance abuse screening, assessment, and/or treatment should: (1) use evidence-based treatment protocols; and (2) continuously monitor quality of care (structure, process, and/or outcomes) using common methods and measures adopted by the field through a consensual process. This should apply to both public and private providers and payors operating in the substance abuse, primary health, social service/welfare, justice, education, or other fields.**

In the alcohol and drug treatment system, reimbursement generally is not tied (or is weakly tied) to meeting specific quality or treatment standards. The goal of this recommendation is to tie the reimbursement eligibility to use of evidence-based practices rather than to cost reduction strategies. The recommendation calls for specific types of reimbursement to be contingent on meeting certain quality and treatment criteria. It would build a stronger framework for accountability in substance abuse treatment if each provider controlled its ability to determine its level of reimbursement. To be reimbursed for substance abuse treatment, providers would have to meet a set of previously defined standards. Coordination with the CSAT Practice Research Collaborative programs and the NIDA and NIAAA Research to Practice efforts will facilitate increased awareness and implementation of such evidence-based practices (see Panel IV Report).

This recommendation calls for the development of a series of tools to monitor quality in an ongoing manner. Quality would be monitored based on both process and outcome data that would be continuously collected. Such standards must be promulgated through a consensual field-wide process. When the tools have been developed, it will be important that they be updated regularly with the evidence gained in the ongoing monitoring process.

Discussion

The Panel's recommendation is based on a commitment, to be made by both provider and payor organizations, to use evidence-based treatment practices. After developing the treatment strategies providers must adopt them, while payors must uphold and adhere to these strategies in their reimbursement decisions. Payors should be monitored to ensure that payment patterns reflect a continued commitment to funding evidence-based treatment, while providers should be monitored to ensured continued use of this treatment.

Some prior recommendations have touched on the development of accountability mechanisms that would directly link quality to reimbursement. ASAM supports the use of ongoing treatment evaluations and case management, cost benefit, and outcome studies as an integral part of ongoing evaluation of all substance use disorder services (ASAM, 1993). An IOM panel recommended the linkage of outcomes research, performance standards, and accreditation to clinical practice guidelines (IOM, 1997b). Another panel recommended an expansion of the Federal government's services research effort to establish the cost effectiveness of alternative strategies and models for treating alcohol problems, and noted that studies of treatment effectiveness should not be undertaken without a consideration of the comparative cost effectiveness question (IOM, 1990a).

C. QUALITY CARE AND OUTCOMES MEASURES

6. **Define and help support processes to reach cross-system consensus on evidence-based standards for quality of care and practices that apply to all systems and payors.**

Currently the system lacks consensus on standards necessary to ensure that treatment plans are consistent and appropriate, regardless of where the individual enters the system. The lack of consistency across the substance abuse treatment system and other overlapping systems negatively impacts the quality of the care provided.

This recommendation is aimed at addressing the need for agreed upon evidence-based standards regarding the quality of substance abuse treatment. The goal is to achieve consensus on new or existing standards and to assure that treatment strategies are consistent across providers, payors, and systems and based on evidence-based practices. It calls for the development of standards to guide substance abuse treatment, including practice protocols that are based on scientific and other practice-related evidence. Standards relating to screening and assessment and quality measurement are inherent in the development of cross-system standards for substance abuse treatment.

A key element of this recommendation is that the standards describing how to deliver all kinds of substance abuse treatment across all systems of care must be further developed. A continuum of care includes education; prevention; screening and assessment; brief intervention and treatment determined by client need, severity of addiction, and co-occurring health problems; and maintenance care. The successful implementation of standards can improve communication and treatment planning across systems.

Discussion

As funding per client has decreased, the substance abuse treatment system often has had to attempt to provide more effective treatment with the same or reduced amounts of resources. These conditions make the establishment of minimum standards crucial. In this time of health cost containment, it is both necessary and possible to have better guidance for how treatment dollars will be used. A failure to accurately diagnose and match an individual to the appropriate treatment program is likely to compromise the success of the treatment, which in turn reduces cost effectiveness.

Because substance abuse disorders have a high rate of associated problems, ensuring that the treatment plan is the most appropriate plan available should reduce costs associated with the care and minimize the possibility of repeat treatment. The Panel believes that establishing system standards will lead to the provision of more coordinated appropriate care in a cost-effective manner so that the system can deliver more effective treatment with the same level of resources.

There are a number of guidelines and protocols available; however, these previous and ongoing initiatives fall short of what the Panel recommends because there is no coordination or consistent use of one protocol or standard, and not all of these standards are evidence-based. For example, ASAM has taken the lead role in the development of practice guidelines; however, without agreement from HCFA, primary care, or the justice system, these guidelines will be used inconsistently.

Lacking a consensus on standards, managed care and other third-party payors create their own standards for treatment. Reimbursement decisions, then, are based on these often idiosyncratic clinical protocols, not necessarily on those that would best meet patient needs. Some managed care organizations (MCOs) develop artificial barriers to access and deny or delay treatment. These practices must be curtailed. The development of treatment standards adhered to by both payors and providers would make these practices more difficult to continue.

Concern about quality of care has sparked numerous recommendations over the years. For example, a 1998 recommendation from an IOM panel stated that:

> *"CSAT, in collaboration with State substance abuse authorities, professional organizations, and consumer organizations in the addiction field should continue the development of evidence-based treatment recommendations (including considerations of short- and long-term outcomes) for use by clinicians of all disciplines involved in the treatment of drug and alcohol use disorders" (IOM, 1998).*

This supported a 1997 IOM report, *Managing Managed Care*, suggesting that the development of clinical practice guidelines be linked to outcomes research, performance standards, and accreditation, noting that performance measures must be relevant to treatment processes and outcomes. A previous recommendation had called for government agencies to conduct studies on the relationship between treatment approaches and patient needs (IOM, 1996). Other recommendations have called for "national, uniform performance standards [that are] applied equally to public and private organizations and systems" and "manageable, measurable and meaningful" performance measures (NASADAD and the American Managed Behavioral Healthcare Association [AMBHA], 1998).

The panel also recognizes that a number of important initiatives have responded to these recommendations including CSAT's Treatment Improvement Protocols (TIPs) and Technical Assistance Publication Series (TAPS). Additionally, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) have worked on accreditation standards for methadone clinics. NIDA has developed a research-based guide, *Principles of Drug Addiction Treatment*, which lists 13 principles of effective drug treatment. The American Psychiatric Association (APA) and ASAM also have developed treatment guidelines. ASAM, in particular, has developed patient placement criteria to ensure that patients are matched to the appropriate level of care (ASAM, 1996). The Panel's recommendation builds on and extends this important work.

For this recommendation to be successfully implemented, many different groups must participate, from government and private provider and payor organizations to research and teaching institutions. The Panel feels that CSAT could assist with the implementation of this recommendation by facilitating discussions and focus groups on this issue. Further, the Panel notes that CSAT should consider using the Block Grant as a vehicle to promote the development and use of evidence-based standards.

7. **Facilitate cross-system consensus on critical data elements to measure quality of care and treatment outcomes.**

This recommendation seeks to expand the inter-system linkages previously discussed by identifying outcome-specific data elements that can accurately capture the quality of care provided. Although the effective use of assessment tools on intake is crucial, the focus of this recommendation is assessment during and after treatment with an emphasis on treatment outcomes. The charge of this recommendation is to develop a common set of data elements to measure and ultimately improve treatment outcomes and enhance the quality of care.

This recommendation also calls for the development of assessment mechanisms that are uniform, ongoing, and evolving and will account for case mix variances across providers. Such mechanisms should be multidimensional and appropriate to specific settings and populations. A complete measurement system should address structure, process, and outcomes. To implement this recommendation, CSAT can, in collaboration with others, fund the development and testing of these data elements.

Discussion

This recommendation is necessary to measure quality consistently. The rising pressure from public and third-party payors for more accountability for treatment and treatment outcomes is also an indicator of the need for ways to measure quality. In the course of developing standard tools for screening and assessment and quality measurement, it is crucial to gain consensus from providers and others involved in substance abuse treatment across the country. Consensus must ensure that the tools are broad enough to account for particular demographic and other differences across settings.

It is widely accepted that there must be performance measurement and treatment outcome measurements for substance abuse treatment (ONDCP, 1999a). These concepts emphasize the need for tools to monitor treatment and outcomes and predicate the effectiveness of the tools on their ability to take into account ethnic and other population specific criteria.

Prior recommendations have addressed the importance of accounting for population characteristics, monitoring quality of care, assessing the effectiveness of varying treatment mechanisms, and the use of consistent data and instrumentation (ASAM, 1996, 1993; NAADAC, 1992; NASADAD and AMBHA, 1998). Plans that serve distinct populations should measure and evaluate the needs of those groups through reviews of research literature, consumer surveys, and other appropriate mechanisms (IOM, 1997b). The same report also recommended that public and private purchasers, consumers, providers, practitioners, behavioral healthcare plans, and accreditation organizations continue to monitor and assess the quality of care.

A key element of monitoring is the determination of the length and intensity of treatment. For example, a 1998 IOM report recommended that CSAT and NIDA develop mechanisms to enable State policy makers to monitor service delivery in community-based treatment programs to determine if consumers receive services demonstrated as effective and to ascertain if the treatment dosage and intensity are sufficient to be effective.

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Report of Panel II: Reducing Stigma and Changing Attitudes

Changing the **Conversation**

THE NATIONAL TREATMENT PLAN INITIATIVE

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Changing the **Conversation**

THE NATIONAL TREATMENT PLAN INITIATIVE

> *"We envision a society where people who are addicted to alcohol or other drugs, people in recovery from addiction, and people at-risk for addiction are valued and treated with dignity; and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. We envision a society where addiction is recognized as a public health issue — a treatable disease for which individuals should seek and receive treatment; and where treatment is recognized as a specialized field of expertise."*
>
> — *The Panel's Vision Statement*

I. Executive Summary

Dependence on alcohol or other drugs is often not understood to be a disease. Similarly, people in recovery from addiction often suffer degradation and discrimination because many do not understand that these individuals have overcome a disease and are not "bad people" or "immoral" or "weak-willed." This stigma can cause ostracism, shame, and even denial of life's necessities — such as employment and a place to live - for which the person in recovery is fully qualified and deserving.

Changing the Conversation initiated the first intensive exploration of the stigmas and attitudes that affect people with alcohol and drug problems. The Panel addressed stigma as a powerful, shame-based mark of disgrace and reproach that impedes treatment and recovery. Prejudicial attitudes and beliefs generate and perpetuate stigma; therefore, people suffering from alcohol and/or drug problems and those in recovery are often ostracized, discriminated against, and deprived of basic human rights. Their families, treatment providers, and even researchers may face comparable stigmas and attitudes. Ironically, stigmatized individuals often endorse the attitudes and practices that stigmatize them. They may internalize this thinking and behavior, which consequently becomes part of their identity and sense of self-worth.

Stigma often causes people to lose self-esteem and confidence in their ability to seek treatment and remain in recovery, to obtain and maintain employment, and to trust the systems intended to assist them. The stigma, whether internal or external, ultimately hinders an individual's ability to participate fully in society.

Public support and public policy are influenced by addiction stigma. Addiction stigma delays acknowledging the disease and inhibits prevention, care, treatment, and research. It diminishes the life opportunities of the stigmatized.

Society tends to group all individuals with substance abuse problems, which prevents them from being seen as individual human beings worthy of treatment. An individual convicted of a crime who also has an alcohol or other drug addiction must receive adequate treatment. In sum, people at risk for, suffering from, or in recovery from alcohol or other drug addiction come in all "shapes and sizes," regardless of gender, race, ethnicity, sexual orientation, religious affiliation, socioeconomic status, and geographic locality. All people should have access to appropriate treatment.

The Panel's recommendations are based on four themes that emerged from the Panel's deliberations and consideration of the eloquent testimony provided in the public hearings: (1) conduct science-based marketing research; (2) launch a social marketing plan; (3) build the capacity of the recovery community; and (4) encourage the respect and rights of people at risk for, suffering from, or in recovery from alcohol or other drug abuse. The development of a common language among criminal justice, mental health, and substance abuse communities and specifically, the replacement of "substance abuse" with an alternate term or phrase, for example, "addiction" was suggested during several hearings.

One complication in establishing a national strategy to reduce stigma and change attitudes is that persons who are addicted or in recovery are perceived by many people in the larger society to have caused their illness. However, recent studies suggest that more persons believe that addiction is a medical condition and that those suffering from the illness should receive professionally indicated treatment.

The Panel proposes a four-point approach for the substance abuse field to reduce the stigmas and change attitudes about people at risk for, in need of treatment for, or in recovery from alcoholism and drug addiction. Family, significant others, support networks, and allies are also included in this model, which comprises the following recommendations:

1. **Conduct science-based marketing research (i.e., polling, surveys, focus groups) to provide the basis for a social marketing plan.** This effort should begin with a language audit to determine problems or opportunities inherent in the language currently used in the field and in public discussions.

2. **Based on the results of the marketing research and language audit, develop and implement a social marketing plan designed to change the knowledge, attitudes, beliefs, and behavior of individuals and institutions to reduce stigma and its negative consequences.** One goal of the plan should be to develop a commonly accepted, clearly worded taxonomy to describe alcoholism and drug addiction and the treatment and services available.

3. **Facilitate and support grassroots efforts to build the capacity of the recovery community to participate in the public dialogue about addiction, treatment, and recovery.**

4. **Promote the dignity of and reduction of stigma and discrimination against people in treatment or in recovery from alcohol or other drugs by encouraging the respect for their rights in a manner similar to people who have suffered from and overcome other illnesses.**

The Panel is particularly concerned about the effect of overlapping and compounding stigmas associated with alcoholism and drug addiction. The stigmas experienced by an individual may vary based on the substance used or the treatment provider. Demographic factors may increase the likelihood and degree of stigma, such as: race, ethnicity, gender, age, religion, employment status, geography, disability, sexual orientation, education, position/profession, lineage, and criminal justice status. The Panel strongly believes that these factors influence human behavior and the extent and degree to which people suffering from addiction will be stigmatized. The relationship among these conditions also affects how and why a particular substance is used, the specific substance(s) used, and which treatment interventions prove to be most effective. Additionally, these demographic factors also affect which treatment and prevention messages and which methods create responses.

II. Understanding the Problem

The National Treatment Plan Initiative (NTP) presented the first opportunity for a concerted exploration of the stigmas and attitudes that affect people with alcohol or drug problems and therefore affect efforts to provide treatment. To provide a context for *changing the conversation*, the Panel explored the types of stigmas and attitudes faced by individuals at risk for, suffering from, or in recovery from alcohol and/or other drug addiction. A review of relevant literature provided the basis for the Panel's discussion of the following issues:

- Definitions of stigma;
- Individual experiences with stigma;
- National efforts to reduce or prevent stigma;
- Public opinion research on addiction;
- Formal approaches to reducing stigma and changing attitudes; and
- Previous recommendations addressing the reduction of stigma and change in attitudes.

The stigma of addiction, like that associated with severe mental illness, physical disabilities, such as blindness or paraplegia, and physical illnesses such as HIV/AIDS, cancer, and Alzheimer's disease, "strikes with a two-edged sword" (Corrigan and Penn, 1999). The first blow is the disease, which is a chronic relapsing medical condition with a complex set of symptoms. The second blow is the stigma associated with the disease of addiction, which is often as debilitating as the disease.

Addiction stigmas subject individuals to various forms of discrimination in a variety of institutions, such as:

- Criminal/juvenile justice,
- Education,
- Employment,
- Housing,
- Health,
- Insurance, and
- Human services.

The Panel agreed that there is no proven strategy for reducing stigma and affecting and changing attitudes directed toward people at risk for, suffering from, or in recovery from alcohol or other drug addiction. Stigma is a long-standing problem that has been addressed by persons with different perspectives using various approaches.

Efforts have been made to reduce stigmas in various arenas including civil and human rights, health care, education, and environmental protection. Social psychologists, health professionals, counselors, law enforcement officials, policymakers, and media professionals have striven to reduce stigmas and change attitudes in the public interest. The roots of stigma are deep, stemming from ancient civilization.

The Panel does not believe that the stigma reduction recommendations cited will eliminate addiction stigma or that they will reduce stigma and change attitudes overnight. Change is an evolutionary process. By using the tactics outlined, though, the general public and target audiences will begin to learn that the disease of addiction is a relapsing medical condition for which proper treatment and a continuum of care are required. The Panel anxiously awaits the time when the disease of addiction is no longer treated as a criminal justice issue, but as a public health problem. Moreover, the Panel embraces the notion of a society that enables any individual with a substance abuse problem, regardless of criminal history, to receive treatment in a safe and respectful environment. The Panel hopes to create a climate in which people who are at risk for, suffering from, or in recovery from alcohol or other drug addiction are valued and treated with dignity.

The Panel hopes that by beginning to change the conversation around the stigma and attitudes associated with the substance abuse field, so too, will the stereotypes about the disease of addiction change. Persons who are addicted or in recovery will play a central role in educating the public about this disease. They will help to create "an environment of respectability and compassion for...people who suffer...from the disease and those who care about them." The Panel believes that their four recommendations will build and strengthen linkages within and among stakeholder communities, organizations, and institutions. Last, the Panel aspires that implementation of these recommendations will bring the Nation closer to realizing its potential as a stronger, fairer, healthier society, as indicated in the Panel's vision statement:

> *We envision a society where people who are addicted to alcohol or other drugs, people in recovery from addiction, and people at-risk for addiction are valued and treated with dignity; and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. We envision a society where addiction is recognized as a public health issue, a treatable disease for which individuals should seek and receive treatment; and where treatment is recognized as a specialized field of expertise.*

A. DEFINITIONS OF STIGMA

The Greeks coined the term stigma to refer to "bodily signs designed to expose something unusual and bad about the moral status of the signified." Today, stigma generally connotes ignominy, a discrediting effect, an "undesired differentness" (Goffman, 1963). There are three general categories of stigmas:

- Abominations of the body: various physical deformities;
- Blemishes of individual character: weak will, domineering, deviant passions, distorted beliefs, and dishonesty, evidenced by, for example, substance abuse, alcoholism, mental disorder, prostitution, imprisonment, or suicidal tendencies; and
- Tribal stigma: race, religion, nationality and gender (Goffman, 1963).

In all three types of stigma, the same sociological features are found:

> *"An individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us. He possesses a stigma, an undesired differentness from what we had anticipated.... [W]e believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (Goffman, 1963).*

Different fields have adapted working definitions of stigma based on recurring themes. For the purposes of this report, the Panel adopted a five-point definition of stigma:

- The stigma of alcohol or other drug addiction is a powerful, shame-based mark of disgrace and reproach.
- Prejudicial attitudes and beliefs generate and perpetuate stigma.
- The result is discrimination directed at individuals at risk for, suffering from, or in recovery from addiction to alcohol or other drugs, and those associated with them.
- People suffering from alcohol or other drug addiction and those in recovery are ostracized, discriminated against, and deprived of basic human rights.
- Often, individuals who are stigmatized internalize such attitudes and practices, making them part of their identity.

B. INDIVIDUAL EXPERIENCES WITH STIGMA

Substance abuse treatment approaches are based on underlying assumptions and viewpoints regarding the individual, the substance used, and the treatment modality. Stigma is associated with certain treatment programs, such as methadone maintenance. Varying degrees of stigma are also related to substance choice, for example, crack cocaine versus powder cocaine; alcohol versus prescription medication. The addict is also stigmatized and often disqualified from full social acceptance. The addict, in many regards, is viewed as predatory and parasitic. However, the addict is not a monolith.

Society tends to group together all individuals with substance abuse problems, which prevents them from being seen as individual human beings worthy of treatment. An individual convicted of a crime who also has an alcohol or other drug addiction must receive adequate treatment. In sum, people at risk for, suffering from, or in recovery from alcohol or other drug addiction come in all "shapes and sizes," regardless of gender, race, ethnicity, sexual orientation, religious affiliation, socioeconomic status, and geographic locality. All people should have access to appropriate treatment.

Research suggests that whereas all persons who are addicted or in recovery are stigmatized, some are stigmatized more than others. More specifically, women, persons of color, youth, the elderly, the poor and the dually diagnosed (i.e., individuals with co-occurring psychiatric and substance related disorders) are more prone to be stigmatized than others with addictive disorders. Consequently, these population groups represent a small percentage of those who actually seek and/or remain in treatment. The Panel acknowledges that these persons and others who are addicted or in recovery need and deserve customized care.

C. NATIONAL EFFORTS TO REDUCE OR PREVENT STIGMA

The Panel, based on the professional experience of its members and outside sources, discussed what other tools health and human service-related fields used to combat stigma and prejudicial attitudes. In the mental health field, government and non-governmental organizations as well as advocacy groups have used various strategies to reduce the effect of stigma on persons with severe mental illnesses. These strategies include protest, education, and contact (Corrigan and Penn, 1999). In the field of HIV/AIDS, a variety of strategies have been used to reduce the stigma associated with this disease, for example, public information campaigns grounded in message-based persuasion, and legislative and regulatory advocacy (Devine, Plant, and Harrison, 1999). The Civil Rights Movement of the 1960s used an entire armamentarium of devices to reduce stigmas and change attitudes about racial and ethnic minorities: constituency building,[1] public education, protest, legislative and legal advocacy, and contact (Corrigan and Penn, 1999).

Upon analyzing activities within the substance abuse field, the Panel discovered that most organized efforts undertaken to reduce stigma and change attitudes have been in the prevention arena, especially through the Center for Substance Abuse Prevention (CSAP). Primarily, these initiatives are aimed at discouraging youth from using alcohol, other drugs, tobacco, inhalants, and preventing driving while under the influence of alcohol. However, the Panel believes that these prevention strategies also can sometimes actually increase the stigma experienced by people at risk for, addicted to, or in recovery from alcohol or other drug problems.

Similarly, the Office of National Drug Control Policy (ONDCP) has instituted a specific prevention goal to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco (ONDCP, 1999). This strategy recognizes that families and communities forge values, attitudes, and behaviors of youth and that they must be positively influenced. To this end, the Strategy includes:

Objective 1: Educate parents or other caregivers, teachers, coaches, clergy, health professionals, and business and community leaders to help youth reject illegal drugs and underage alcohol and tobacco use.

Objective 10: Support and highlight research, including the development of scientific information, to inform drug, alcohol, and tobacco prevention programs targeting young Americans.

Although to date no specific recommendations have been advanced nationally for reducing stigmas and changing attitudes associated with addiction, a new objective in development under ONDCP's National Drug Control Strategy 2001 focuses on reducing stigma.

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[1] The Civil Rights Movement organized The Coalition of Conscience — a broad and diverse group of individuals and associations including the faith community, organized labor, women's organizations, community based organizations, professional, social, fraternal and Greek Letter organizations.

D. PUBLIC OPINION RESEARCH ON ADDICTION

One complication in establishing a national strategy to reduce stigma and change attitudes is that persons who are addicted or in recovery are perceived by many people in the larger society to have caused their illness, unlike persons with other illnesses. However, recent public perception research regarding people addicted to alcohol or other drugs and people in recovery offers reason for cautious optimism. Poll data suggest that today, more persons are aware that someone they know and care about is suffering from an addiction. More persons believe that addiction is a medical condition and that those suffering from the illness should receive professionally indicated treatment.

As part of the Panel deliberations, members reviewed the paucity of existing public opinion research conducted to date. Such findings available on drugs, alcohol, and addiction reported:

- Sixty-nine percent knew a friend or acquaintance with an alcohol or other drug problem. Fifty percent indicated that there is a problem in their family (Hazelden, 1999).
- Fifty-seven percent described "drug abuse" as an extremely or quite serious problem in their community. Fifty-one percent indicated that "alcohol abuse" is extremely or quite serious (The Field Institute, 1998).
- Ninety-six percent strongly agreed that treatment should be available to all persons who need it, although only twenty-four percent characterized treatment as very effective (Hazelden, 1999).
- Seventy-three percent reported believing that addiction is a disease (Hazelden, 1999).
- Fifty-three percent viewed drug abuse as a public health problem best handled by prevention and treatment programs, rather than a crime problem best handled by the criminal justice system (Drug Strategies, 1995).
- Fifty percent favored requiring drug users to enter court-supervised treatment rather than jail (Drug Strategies, 1995).

Additionally, news accounts are helping to increase public awareness about the disease of addiction. A September 9, 1999 *Wall Street Journal* article summarized the findings of an annual household survey conducted by the Department of Health and Human Services (DHHS).[2] The survey found, most notably, that:

- Seven of ten people who used illegal drugs in 1997 had full-time jobs.

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[2] *"Report Finds 70% of Illegal-Drug Users Hold Full-Time Jobs, Dispelling Stereotype"*

- Young adults, men, whites, and those with less than a high school education were more likely to use drugs than other workers.

The general lack of data suggests the need for a greater understanding about the chronic relapsing nature of the disorder of addiction. Panel members also identified the general public's lack of confidence in substance abuse treatment. Whereas the above data are far from definitive, they indicate that the public has grown more empathetic to addicted persons and treatment over the years. The empathy may be grounded in part in the realization that substance abuse crosses racial, ethnic, gender, and socioeconomic sectors. The empathy may be rooted in the increase in public information about the disease of addiction and persons who are addicted or in recovery. The data also suggest the need for greater public awareness about the etiology of the disease of addiction and the effectiveness of treatment.

The data and a review of stigma reduction efforts in other fields led the Panel to conclude that providing greater information to the stigmatized, those who stigmatize, the public at large, and those who affect the perceptions of the public, such as policymakers and the media, should be a central component of any stigma reduction effort. Education must not be the sole component of the stigma reduction strategy. Education can help change attitudes and break down some barriers to understanding the disease of addiction. Advocacy is needed to create an environment that will likely change behaviors. Data indicate that new information may change attitudes, but will likely not change behaviors.[3, 4]

E. FORMAL APPROACHES TO REDUCING STIGMA AND CHANGING ATTITUDES

The Panel considered a range of models to determine the best approach to reduce stigma and change attitudes about persons at risk for, suffering from, or in recovery from addiction to alcohol or other drug addiction and those associated with them. The approaches considered include: public service campaigns (PSCs); comprehensive community-based health communications campaigns; "strategic media" or "media advocacy"; and social marketing.

PSCs can be one effective component of an overall public health mass media campaign. They can increase public recognition of a problem and establish it as a primary concern (Drug Strategies, 1995). A sponsoring organization can be positioned as an agent of change by PSCs. For example, by adding a hotline number, callers can get additional information about a public health problem, legislative and regulatory action relating to the problem, and ways to obtain more information

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[3] Some suggest that attitude change follows, rather than precedes, behavioral change (NIAAA, 1995). Those who subscribe to this school of thought postulate, for example, that a change in a law, policy or practice may prod a change in attitude by inducing behavioral change. Research on the cognitive dissonance effect supports this position.

[4] Other respected social psychologists share the views of Corrigan and Penn, Krauss, and Petty that attitude-behavior relationships are not bivariate but, rather, are multivariate. As such, changing attitudes/beliefs will not necessarily result in changing behaviors.

(Drug Strategies, 1995). An effective PSC also provides information to bolster public receptivity to initiatives announced through press conferences and other vehicles (Drug Strategies, 1995). PSCs can generally raise awareness about public health concerns and contribute to attitude changes. PSCs focus on a general audience to increase awareness or motivate personal behavior. However, standing alone, they have not been found to affect behavior.

Comprehensive community-based health communications campaigns that include the mass media are proven to be effective in changing attitudes in several public health areas, including alcohol and tobacco (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1995). They have been used successfully to disseminate knowledge. However, these campaigns have been less effective in changing health-related behavior. When behaviors are ingrained, more intensive instruction is needed to foster a change in the behavior. A strategy "that encourages the learner's active participation and provides corrective feedback" will likely be most effective (NIAAA, 1995).

Media advocacy is "the strategic use of mass media to advance a social or public policy initiative" (Advocacy Institute, 1992). It seeks to promote a paradigm shift from the traditional public service announcements relied on by many organizations to a more proactive approach. Media advocacy focuses on the social, political, and economic environment of a causative factor in health problems. It advances policy solutions to the problems. Media advocacy gives communities a voice with which to define problems and promote policy solutions. Media advocacy seeks to shift the focus of the media from unhealthy behavior of particular individuals to policy approaches and changing the environment. It integrates a variety of methods to reduce stigmas and change attitudes, taking advantage of "multiple entry points" to "raise the salience of issues on the Nation's legislative and public policy agenda" (Advocacy Institute, 1992). Media advocacy tactics include: conducting scientific research (focus groups, polling); identifying messages, themes, and symbols; building coalitions; coordinating media activities; and taking advantage of economies of scale by sharing technology and research (Advocacy Institute, 1992).

Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Enoch, Rohrbaugh, Davis, Harris, Ellingson, Andreason, Moore, Varner, Brown and Eckardt, 1995). It is also designed to promote "involuntary change" for example, by law, regulation, or administrative fiat in the public interest or among target audiences. Social marketing has grown out of an understanding that people will not necessarily change or adopt behaviors simply because they are provided information. People need to be persuaded to act, often by reducing barriers that prevent the desired behavior or offering incentives to change their attitudes and behaviors (Academy for Educational Development, 2000). Social marketing also recognizes that the environment (i.e., government regulation, social norms, processes and procedures) in which individuals make behavioral decisions often needs to change as well.
To ensure change and measurable success, social marketing has become a multifaceted process that

includes research, program planning, design, execution, and evaluation. Research drives the planning process, allowing program designers to create programs that focus on target audiences with carefully developed messages. Social marketing campaigns use multiple tactics for change including coalition building and network development techniques, mass media vehicles, interpersonal delivery systems, and other commercial marketing technologies and advocacy strategies.

F. PREVIOUS RECOMMENDATIONS ADDRESSING THE REDUCTION OF STIGMA AND CHANGE IN ATTITUDES

The Panel resolves that the stigma reduction tactics ultimately used should be grounded in established principles and models based on findings from previous efforts to promote voluntary behavior change to improve personal or public welfare. Some of these ideas are briefly noted here.

- Stigma reduction requires a long-term commitment to creating change. Changing norms, values, and policies is a complex undertaking that may require years to accomplish, as evidenced by the evolution of changes in tobacco use (Hahn, Charlin, Sussman, Dent, Manzi, Stacy, Flay, Hansen and Burton, 1990).
- The behavior change theories should be applied directly to the problem. Social learning and communication theories can provide the necessary structure for developing interventions that move people from awareness to skill development to behavior change to behavior maintenance (Mok, Laing, and, Farquhar, 1984; Flora, Maiback, and Maccoby, 1989).
- Apply the consumer orientation of social marketing, which uses a consumer perspective, to develop, package, and implement interventions, with an emphasis on consumer benefits (Lefebvre and Flora, 1988). Audience segmentation, channel analysis, presenting, and other types of formative research are necessary to develop an effective campaign (Atkin and Freimuth, 1989).
- Using multiple channels of mass communication is the best strategy for reaching the intended audience. Television tends to be considered the final product of media campaigns, but depending on the audience, it may be the least effective and least economic approach. Reinforcing the message through various communication channels can enhance the message and better ensure that the target population is reached (Atkin and Arkin, 1990).
- Strategically using entertainment and news programming will provide more exposure for the topic. Several advocacy groups have been effective in inserting their message into prime-time entertainment programming. Sometimes groups can use "social problem" or "disease of the week" television movies to increase audience exposure to their particular topic. Other groups have been able to promote news stories that give their topics added exposure (NIAAA, 1995).

Taken together, previous experience and studies suggest the following approaches may be effective.

- Stimulating interpersonal communication will increase the likelihood of behavior change by reinforcing the message and supporting the expected change. Taking steps such as purchasing media time and space will ensure that the intended audience is exposed to the campaign. Other strategies include working with local media outlets to encourage them to sponsor the campaign, thus giving it higher visibility. For some issues, corporate sponsorship might be appropriate.
- Media strategies should be linked with community-based programs. Virtually every mass media campaign that has shown any evidence of success has been supplemented with community-based programs. The most effective and sustained campaigns include coalition- and capacity-building programs. Using media alone, except in rare situations, is unlikely to produce a positive effect.
- The mass media can focus attention on social, economic, and cultural factors that affect health behavior. Changing individual behavior may be necessary, but insufficient, to stimulate improvements in health status. Alcohol, tobacco, and nutrition groups are increasingly shifting attention to broader social factors as part of the prevention and social change process.
- Public affairs strategies need to be integrated with public policy strategies because changing behavior sometimes requires changing laws and policies. In these instances, media and advocacy activities should be designed to change the laws and policies necessary to prod behavioral change.
- Finally, process evaluation should be used by program managers to judge how well their intervention is being delivered to the intended audience. Outcome evaluation will let managers know if planned key goals and objectives are being met.

Building on these ideas and the models used for stigma reduction and attitude change in other fields, the Panel developed a four-point model for reducing the stigmas and changing the attitudes associated with addiction and recovery. This model is described in more detail in the Recommendations (see Section IV of this Panel report).

III. Themes from the Public Hearings

As part of the National Treatment Plan Initiative, The Center for Substance Abuse Treatment convened six public hearings to gather input from a broad and diverse group of stakeholders about ways in which to improve the availability, accessibility, and quality of substance abuse treatment services and outcomes. More than 400 people participated in the public hearings.

At the NTP public hearings, witnesses from across the country testified about the effect of compound stigmas on specific groups. A diverse group testified about their experience with stigma, and its effect on them or their family member, significant other, or friends seeking and/or remaining in treatment. The following examples provide a sense of the range of experiences:

- *Older adults: Masks signs of addiction as part of the aging process.*
- *Women: Prevents them from having their gender-specific treatment needs met.*
- *Gays, lesbians, bisexuals, and transsexuals: Prevents them from having their unique treatment needs met.*
- *Youth, especially African American and Latino youth: Results in numbers of these young persons receiving "time" rather than treatment for non-violent, drug-related crimes; prevents them from being placed in post-incarceration programs to reintegrate them into schools, vocational/technical training programs, families, and/or a job.*
- *Dually diagnosed individuals with mental illness and substance abuse problems: Leads to improper medical treatment, inadequate human services, homelessness, and incarceration.*
- *Children of persons in recovery or suffering from addiction: Hinders their ability to make friends, excel in school, obtain and retain employment.*
- *Persons in drug sub-cultures and second and third generation addicts: Creates multiple barriers to these persons receiving adequate and appropriate treatment.*
- *Persons living in rural areas or on reservations: Face unique geographic and cultural barriers to treatment.*

Multiple and overlapping stigmas need to be addressed by considering the effect of race, ethnicity, gender, socioeconomic status/class, and compounding medical conditions (HIV/AIDS, cancer, mental health conditions). Consensus emerged that the public should be educated about the disease of addiction. To put a human face on the disease of addiction, the recovery community must play a key role in changing attitudes toward people in recovery, addiction, and substance abuse treatment. People in recovery should serve as role models/examples of the success of treatment. The unique treatment needs of specific populations (e.g., Native Americans, older adults, women, children and adolescents, drug subcultures, second- and third-generation addicts and children of parents in recovery) also should be recognized. Last, the classification of addiction as a disease should be reflected in legislation, regulatory, and administrative changes.

IV. Recommendations

The impetus behind these recommendations lies at the crux of the language that is used in everyday vernacular. The Panel laments that the words society uses are stigmatizing, from which prejudicial knowledge, attitudes, and beliefs stem. Therefore, the Panel incorporates a language audit and taxonomy development for the substance abuse field in its first two recommendations, respectively.

1. **Conduct science-based marketing research (i.e., polling, surveys, focus groups) to provide the foundation for a social marketing plan.**

The Panel recommends that the initial step in the process of reducing the stigmas and changing the attitudes about people with alcohol or other drug addiction, people in or seeking recovery and their families, significant others, support networks, and allies, must be to conduct science-based marketing research, which should begin with a "language audit" to identify terms that contribute to stigma and negative attitudes. This research is needed to provide baseline data and benchmarks for the development and implementation of a social marketing plan that includes a language audit.

Discussion

The Panel proposes that this recommendation be implemented through a public/private partnership catalyzed by CSAT with other Federal and nongovernmental organization participants and stakeholders. More specifically, the Panel recommends that the research should be: (1) conducted by relevant independent, external experts; (2) recognize relevant representational and diversity issues including race, ethnicity, gender, age, culture, sexual orientation, disability, socioeconomics, and geography; and, (3) acknowledge individual experiences with and the effect of addiction on the people with alcohol or other drug addiction and people in or seeking recovery and their families, significant others, and allies, as well as treatment providers and researchers.

Implementation of this recommendation should begin immediately in order to gather baseline data upon which to design, pre-test, execute, and evaluate a social marketing plan. Ongoing tracking of the implementation of this Panel's recommendations should be an integral component of implementation plan in order to evaluate the outcomes of the interventions. Monitoring should continue for at least one full year after the implementation plan is completed to obtain the best evaluative data on the effect of the interventions.

The impetus for this recommendation is the paucity of science-based market research about the current knowledge, attitudes/beliefs, and attitude-driven behaviors about and toward people in or seeking recovery and their families, significant others, support networks, and allies. Only piecemeal research about the size of the market and the demographic details exists. No current baseline upon which to measure a reduction in stigma and/or changes in attitudes is available. The proposed science-based marketing research would provide the basis upon which to design, conduct, and evaluate the social marketing plan proposed in Recommendation Two.

2. **Based on the results of the marketing research, develop and implement a social marketing plan designed to change the knowledge, attitudes, and beliefs of individuals and institutions to reduce stigma and its negative consequences.**

The Panel recommends that a social marketing plan should be developed and implemented using the science-based marketing research obtained in the implementation of Recommendation One, above. Additionally, the language audit conducted as part of Recommendation One will be used to develop a taxonomy, or clear categorization for substance abuse and addiction. Social marketing is a program planning process designed to promote voluntary behavior changes in target audiences by reducing barriers people face, using persuasion, and creating a demand for the desired outcome. The proposed social marketing plan would use coalition-building and network development techniques, mass media vehicles, interpersonal delivery systems, other commercial marketing technologies and advocacy strategies to create a climate that supports increased treatment funding and acceptance of people in or seeking recovery and their families, significant others, support networks, and allies.

Discussion

CSAT and a range of stakeholders and associations should be involved in the planning, funding, implementation, and analysis phases of this recommendation. Many groups will play a role in the implementation: the recovery and treatment communities, faith communities, policymakers, educators, criminal and juvenile justice officials, community-based associations, labor unions, human services organizations, health professionals, mental health professionals, and civil rights organizations.

Communications experts, social psychologists and the Panel embrace three prevailing schools of thought on reducing stigmas and changing attitudes:

- Stereotypes, prejudice, and discrimination are beliefs, attitudes, and attitude-driven behaviors that will change when people's attitudes change.
- Attitude-behavior relationships are not bivariate, but multivariate and therefore, changing attitudes/beliefs will not necessarily result in changing behaviors.
- Attitude change follows rather than precedes behavior change.

The social marketing plan recommended by the Panel should include features that incorporate all three schools of thought.

The Panel recognizes social marketing as an effective way to "influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Enoch, et. al., 1995). The social marketing plan should be designed to combine mass media, interpersonal, and community organization approaches to change behaviors. The plan should involve a broad consortium of grassroots organizations in a bottom-up effort to reduce stigma and change attitudes. An attendant result will likely be the strengthening of the addiction constituency and community-based leadership.

The science-based research obtained in Recommendation One will dictate the design and approach of the social marketing plan. However, the Panel recommends consideration of at least the following tactics:

- Identify and acquire necessary resources to implement the plan.
- Design and execute a public education campaign.
- Develop a more active and public recovery community. Highlight success stories of recovering people and their families in an effort to put a human face on addiction and recovery.
- Use biological and scientific data that demonstrate that addiction is a disease — a relapsing medical condition for which proper treatment and a continuum of care are required.
- Develop and use an identifiable campaign theme.
- Build third party coalitions.

The social marketing plan should include public education and advocacy campaigns. The public education campaign should promote voluntary behavior change based on the delivery of targeted, accurate messages about alcohol or other drug addiction; people in or seeking recovery and their families, significant others, support networks, allies and/or treatment providers; and other addiction health care and human services workers. The advocacy campaign should build a grassroots network to change the attitudes of key decisionmakers and elected officials.

3. **Facilitate and support grassroots efforts to build the capacity of the recovery community to participate in the public dialogue about addiction, treatment, and recovery.**

The Panel recommends that the coalition building of the recovery community will occur simultaneously with the implementation of Recommendations One and Two. The tools (i.e., surveys, focus groups, and network development) developed and used for each of these recommendations serve as a basis for capacity-building of the recovery community at the local and grassroots levels.

Discussion

The Panel suggests that this recommendation be implemented by a coalition that may include the private sector, foundations, faith organizations, corporate funders, purchasers of health care, education institutions, people in recovery, family members affected by addiction, community-based organizations, and professionals in the field. Government agency involvement in the implementation of this recommendation will be limited to enable this effort to devolve fully and flourish at the local level.

The coalition created for the implementation of this recommendation should conduct activities such as the following:

- Create tools, toolboxes, message and educational materials, and guidelines to establishment grassroots organizations and conduct stigma reduction education campaigns.
- Partner with community-based, non-profit organizations and professional associations to co-sponsor a national planning conference.
- Convene three consecutive national annual forums to create opportunities for people who are at-risk for, suffering from, or in recovery from alcohol or other drug addiction, and those associated with them to network and organize. These forums should mirror in microcosm what the Panel did in macrocosm.
- Encourage and support community-based non-profits to conduct regional public education conferences to enhance existing groups and encourage the establishment of new groups.
- Continue to provide economic and technical support to local recovery groups.
- Provide funding and technical support to grassroots organizations comprised of people in recovery and their family members. This would include providing materials, peer mentoring, training, networking opportunities, and communications assistance; and convening conferences.

The Panel believes that implementation of this recommendation would: increase stakeholder involvement; broaden the base of involvement in the support network; increase the credibility of the movement; strengthen the bonds among the stigmatized population; and build a collaborative structure for the recovery community to network and organize.

Implementation of this recommendation should begin immediately and continue until an apparent need for a public dialogue on addiction, treatment, and recovery no longer exists. The Panel proposes this recommendation in the hope of establishing an organized, visible, and vocal constituency that carries the message of addiction recovery to targeted audiences and the general public.

4. **Promote the dignity and reduction of stigma and discrimination against people in treatment for or in recovery from alcohol or other drug addiction by encouraging the respect for their rights in a manner similar to people who have suffered from and overcome other illnesses.**

The Panel strongly believes that the rights defined for people in recovery in two Federal Acts, the Americans with Disabilities Act (ADA) and Rehabilitation Act represent the model for all laws, policies, and practices. In other words, individuals with a history of addiction should be treated the same as other persons, including others with a history of a disability. This model successfully balances public and private rights by simultaneously prohibiting discrimination against those persons with a history of disability who are qualified, and providing no protection to individuals whose history of disability renders them unqualified.

Discussion

The ADA and Rehabilitation Act, and the State and local laws based on these Acts, have been very effective in protecting many people in recovery from discrimination without compromising other social interests. The two acts have either directly or indirectly enabled thousands of people in recovery, including those in treatment, to obtain jobs, housing, human services, health care, and other necessities.

Despite the great progress achieved by these laws, and by similar policies enacted in much of the private sector, stigma and discrimination against people in recovery, including those in treatment, remain all too prevalent. The Panel recommends that CSAT convene a broad and diverse coalition to implement this recommendation. This coalition should include persons in the recovery community, public officials and policymakers, health opinion leaders, mental health opinion leaders, treatment providers, health and human services officials, journalists/media, research scientists, educators and training professionals, clergy and faith organizations, organized labor, business leaders, civil rights attorneys and organizations, foundations, and other advocates in related areas

The Panel believes that implementing this recommendation will:

- Reduce labeling/stereotyping.
- Recognize that individuals with addictive disorders have the same rights as others with a history of disability.
- Acknowledge the disease of addiction as a public health issue.
- Empower people in recovery who are still stigmatized to maintain recovery and enjoy the full benefits of society.

- Encourage people with addictive disorders to seek treatment by reducing the fear of discrimination.
- Expand substance abuse treatment options.
- Make laws, policies, and practices more consistent with the Federal Americans with Disabilities Act and Rehabilitation Act; and consequently, promote more effective and cost-efficient national policies.

This recommendation should be implemented immediately and continuously until a reduction in the disparate treatment of people with addictive disorders is achieved.

Dependence on alcohol or other drugs is often not understood to be a disease. Similarly, people in recovery from addiction often suffer degradation and discrimination because many do not understand that these individuals have overcome a disease and are not "bad people" or "immoral" or "weak-willed." This stigma can cause ostracism, shame, and even denial of life's necessities — such as employment and a place to live — for which the person in recovery is fully qualified and deserving.

The Panel believes that laws, policies, and practices inconsistent with the requirements of the Federal Americans with Disabilities Act and Rehabilitation Act: (1) encourage, promote, and foster prejudicial attitudes and beliefs as well as discriminate against individuals in recovery from alcohol or other drug addiction; (2) deter diagnosis and entry into treatment; and (3) deprive persons in recovery of basic human rights. The focus of this recommendation is to combat discrimination and stigma against people in treatment or in recovery from alcohol or other drugs. This recommendation does not address laws, policies, and practices related to current addiction to alcohol or other drugs.

The proposed recommendation is designed to induce change in behaviors and, in turn, lead to a positive shift in public attitudes and beliefs about persons in the recovery community. The recommendation is targeted to policymakers, regulators, judges and other law enforcement officials, corporations, medical education officials, continuing medical education (CME) certification officials, and medical licensing authorities.

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Report of Panel III: Improving and Strengthening Treatment Systems

Changing the **Conversation**

THE NATIONAL TREATMENT PLAN INITIATIVE

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I. Executive Summary

Substance abuse disorders affect a wide range of individuals from all walks of life, and involve the use of various substances ranging from alcohol to illicit drugs. Substance abuse is a recurring disorder that affects the individual's medical/physical, psychological, and social functions. Because the disorder itself is highly complex, the system that has evolved to treat it is equally complex. The philosophy guiding the Panel's deliberations was that the core of successful treatment must be the client and the client's needs.

The specialty substance abuse sector is a comparatively new and diverse system that has developed in relative isolation from other health and human services systems over the past 30 years. The proliferation of diverse community-based organizations (CBOs) around the country, most of which are mission driven and focused on a single basic program of care, is a result of the evolution of the system. Today's diverse treatment system can be characterized as a group of organizations providing culturally sensitive care in program or service-based settings with limited financial resources. This report highlights some of the system's strengths while also identifying some problems, including:

- Treatment planning that is program based rather than client centered;
- Inconsistent use and application of available tools to match client need to treatment;
- Insufficient financial resources;
- Changing payor relationships and insufficient reimbursement; and
- Inadequate management skills and inconsistent business practices.

Panel members believe that to effect change, the following recommendations should be implemented:

1. **Treatment plans should be based on an individual's needs and should respond to changes in need as he or she progresses through stages of treatment. Evidence-based practices should guide screening, intervention, assessment, engagement, individual and group therapies, aftercare, and relapse prevention so that the individual enters at an appropriate level of care, becomes engaged in services, and progresses through a continuum of care.**
2. **Reimbursement mechanisms should be aligned with treatment goals and should incorporate performance measures and outcome standards to guide resource allocation as well as rates sufficient to cover both reasonable costs and a surplus to support reinvestment.**

3. **Treatment programs, payors, and regulators should promote organizational cultures that improve the quality, effectiveness, and efficiency of services through the adoption of best business practices for program management and operations. These should include effective governance and leadership for the board of directors and senior management; management and operation of human resources, marketing, and finance; information and data management operating systems; and capital and facilities.**

These three recommendations comprise the framework that the Panel believes is essential to improve and strengthen substance abuse treatment systems.

II. Profile of the Current Treatment System

Many diverse organizations throughout the country provide substance abuse treatment, using various approaches in outpatient, inpatient, and residential settings. Both providers and government agencies generally focus on either alcohol or drug problems. Frequently treatment programs have been established to provide a specific program or service to a designated population. The end result is a system in which no two organizations are alike and the approaches to treatment are as diverse as are the providers.

A. FACILITIES AND SERVICE

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Facility Data Set (UFDS), there were approximately 10,800 treatment facilities in the United States in 1997. More than 80 percent of those treatment facilities were private organizations (not-for- and for-profit). The remainder comprised government-owned Federal, State, and local entities. However, public funds pay for nearly two-thirds of all treatment. Due to organizations' limited capacity and access to resources, more than 75 percent of facilities serve fewer than 100 clients.

Based on their available resources, most organizations are able to provide only a limited array of services. Nearly two-thirds of all facilities provide outpatient, non-methadone services, making this the most common form of care (Horgan and Levine, 1998) (see Figure III.1). About 17 percent of the facilities are residential, while only three percent of all facilities have inpatient units. Most of these facilities, although collectively covering a wide range of services, do not provide a full continuum of care. Individual therapy, comprehensive assessment, and group therapy are the most common services offered. Maintenance services such as family counseling, aftercare, and relapse prevention are offered in almost all facilities, but outcome follow-up is offered in only 66 percent of the facilities. Fewer than 25 percent of facilities offer academic classes, smoking cessation programs, prenatal care, or childcare.

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Figure III.1. Type of Care

Facility	*Percent of Providing Care*
Inpatient	3.0
Residential	17.4
Outpatient Methadone	5.0
Outpatient Non-Methadone	61.1
Inpatient and/or Residential with Outpatient Non-Methadone	13.6

Source: Horgan and Levine (1998)

B. THE CLIENT POPULATION

October 1997 estimates showed 929,086 clients in treatment, with approximately 55 percent of those in private not-for-profit facilities (SAMHSA's UFDS data, 1997). The most common reasons for entry into treatment are alcoholism and heroin or cocaine abuse (Horgan and Levine, 1998) (see Figure III.2). Nearly 69 percent of all patients treated are men. Although studies indicate that ethnic populations are at high risk for substance abuse disorders, the majority of patients in treatment are white men, highlighting the concern that the current system is not effectively reaching certain populations (e.g., women, juveniles, the physically challenged, and many ethnic or culturally diverse groups) (SAMHSA's UFDS data, 1997). The treatment programs targeting these populations are limited in number and often difficult to access.

The criminal justice system is the largest referral source of clients, accounting for approximately 34 percent of those in treatment. Voluntary or self-referrals are the next largest source of treatment referrals, comprising 21 percent of the total. Various inter-system linkages, including other health-care providers and human services agencies, accounted for 16.6 percent of clients.

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Figure III.2. Patient Characteristics

Race Ethnicity	Percent of Patients	Age	Percent of Patients	Primary Drug Being Treated	[illegible]
White	57	<18	8	Alcohol	43
Black	24	18-24	13	Heroin	18
Hispanic	12	25-34	31	Cocaine	15
Asian	1	35-44	28	Marijuana	10
Native American	3	45+	14	Amphetamines	3

Source: Horgan and Levine (1998)

C. QUALITY OF CARE

The quality of treatment varies across the treatment system. There is no system-wide, agreed-upon quality measurement protocol. However, various generally accepted indicators are used, particularly length of stay and retention rates. Currently, the field relies on an array of approaches to assess quality of care, including the use of performance measures, practice guidelines, accreditation, licensing and certification, credentialing and privileging, and report cards (Institute of Medicine [IOM] Managing Managed Care Report, 1997).

In response to the need for quality improvement initiatives, CSAT's Office of Managed Care convened the Washington Circle Group (WCG) in March 1998 to improve the quality and effectiveness of substance abuse services through the use of performance measurement systems. The March 2000 WCG report emphasized that core measures should consider external accountability, the extent to which a healthcare system meets a pre-existing agreed-upon standard; and accountability for the entire process of care, such that the service delivery level should be equal to the level of responsibility for overall performance measurement.

Another mechanism designed to promote quality care is the American Society of Addiction Medicine's (ASAM) Patient Placement Criteria. Through the Patient Placement Criteria, ASAM established a set of diagnostic criteria to create standards for decision-making for placement, continued stay, and discharge of patients with alcohol and other drug problems. Accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) have incorporated measures that involve substance abuse treatment in their evaluation of programs.

D. EFFECTIVENESS OF CARE

Changes in purchase of service contracts are accelerating the evolution of performance and outcome monitoring. Increasingly, State and Federal governments are implementing contracts that require demonstrations of specified levels of outcomes rather than just purchasing the delivery of services. Many studies show that treatment is an effective strategy that enables individuals with substance abuse disorders to lead productive lives. Effectiveness of substance abuse disorder treatments can be measured through an array of indicators that capture the breadth of the treatment process itself. Treatment outcomes can include direct reduction in drug use, improved functioning at work, improved general and mental health status, reduced crime, reduced domestic violence, and reduced engagement in at-risk behavior for HIV infection.

Two national studies funded by SAMHSA support the effectiveness of substance abuse treatment programs, the National Treatment Improvement Evaluation Study (NTIES, 1997) and the Services Research Outcomes Study (SROS). NTIES showed that with treatment:

- Primary drug use was decreased by 48 percent;
- Reported alcohol/drug-related medical visits declined by 53 percent;
- Criminal activity decreased by as much as 80 percent;
- Illicit drug use for young adults (ages 18–20) declined by 47 percent; and
- Client financial self-sufficiency improved (i.e., employment increased by 19 percent, welfare recipients declined by 11 percent, and the proportion of clients who reported being homeless at some point during the previous year dropped by 43 percent).

SROS also showed the substantial benefit individuals receive from treatment. Specifically, SROS showed that: there was a 21 percent decrease in the use of any illicit drug following treatment; those remaining in treatment for longer periods were more likely to reduce or eliminate the abuse of substances following treatment; there was a substantial decrease in crime; and more reliable housing was secured after treatment.

The National Institute on Drug Abuse (NIDA) initiated The Drug Abuse Treatment Outcome Studies (DATOS) in 1990 to evaluate drug abuse treatment outcomes and emerging treatment issues in the United States. DATOS results were similar to those seen in NTIES. For example, criminal activity and unemployment were decreased when an individual entered treatment, regardless of the treatment setting. Furthermore, the DATOS study revealed that clients who remained in treatment for three months or longer consistently showed significantly more favorable follow-up outcome measures than those who left before they reached the three-month mark.

E. ROLE OF GOVERNMENT

Much of the nation's substance abuse resources are directed at curbing the supply of drugs and at law enforcement programs, rather than at reducing demand for drugs through treatment and prevention initiatives. According to The White House Office of National Drug Control Policy's (ONDCP) 1999 National Drug Control Strategy, the Federal government spends about $6 billion on demand reduction activities for illicit drugs, less than half the amount it spends on supply reduction.

Treatment programs, together with research, constitute a major demand reduction strategy. Federal dollars allocated for treatment and research in fiscal year 2000 are $3.6 billion, slightly more than one-third the amount allocated for domestic law enforcement ($9.2 billion). According to the best current estimate, in 1996 $12.6 billion was spent on alcohol and substance abuse treatment, with public funds (Federal and State) accounting for 63 percent, or nearly $8 billion (McKusick, Mark, King, Harwood, Buck, Dilonardo, and Genuardi, 1998). This was an increase from 1986, when public funding accounted for 53 percent of total substance abuse expenditures. Federal dollars, including the Federal government's share of Medicaid, Medicare, Department of Defense (DoD), and the Veteran's Administration (VA), paid for nearly one-third of national expenditures on substance abuse treatment funding. The State/local share was approximately equivalent at 31 percent of national expenditures.

As the country's drug crisis has grown over the past 30 years, Federal and State governments have responded by passing legislation that addresses pertinent issues. To understand how the treatment system has evolved, it is important to understand the organizations that regulate, oversee and/or promote treatment.

The ONDCP is charged with producing a National Strategy, which directs the nation's anti-drug efforts and establishes a program, budget, and guidelines for Federal, State, and local cooperation. The ONDCP also evaluates, coordinates, and oversees both the international and domestic anti-drug efforts of executive branch agencies, and ensures that such efforts sustain and complement State and local anti-drug activities.

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SAMHSA provides national leadership to ensure that science-based knowledge and state-of-the-art practices are effectively used for prevention and treatment of addictive and mental disorders. SAMHSA was established in 1992 by P.L. 102-321, which divided substance abuse and mental health programs into a research focus at the National Institutes of Health (NIH) and a services focus at SAMHSA. SAMHSA was charged with improving the quality and availability of prevention, treatment, and rehabilitation services in the United States in order to reduce illness, death, disability, and cost to society from substance abuse and mental illnesses. Further, a SAMHSA goal was to improve access and reduce barriers to high quality, effective programs and services for individuals who suffer from or are at risk for these disorders, as well as for their families and communities.

Within SAMHSA, the Center for Substance Abuse Treatment (CSAT) retains the primary responsibility for treatment programs, while the Center for Substance Abuse Prevention (CSAP) focuses on prevention activities. Among CSAT responsibilities are administering the Substance Abuse Prevention and Treatment (SAPT) Block Grant, supporting knowledge development and application projects, conducting evaluations, and providing technical assistance to states and Block Grant subrecipients. The Federal SAPT Block Grant is the cornerstone of funding for State substance abuse programs, accounting for about 47 percent of all public funds expended for treatment and prevention. Formula-driven, the Block Grant includes several mandatory distributions and set-asides that States must follow to receive the funds. The Block Grant provided $1.59 billion in alcohol and substance abuse treatment spending in fiscal year 1999. The following statistics highlight the importance of the Block Grant:

- In 1997, 19 states reported that the Block Grant provided the majority of their funding for substance abuse treatment services.
- More than 7,000 community-based organizations receive Block Grant funding.
- In fiscal year 1998, SAPT Block Grants supported treatment for an estimated 300,000 individuals.

Within the NIH, the National Institute on Drug Abuse (NIDA) supports more than 85 percent of the world's research on the health aspects of drug abuse and addiction. NIDA is not only seizing unprecedented opportunities and technologies to further the understanding of drug abuse effects on the brain and behavior, but also is working to ensure rapid and effective transfer of scientific data to policymakers, drug abuse practitioners, other healthcare practitioners, and the general public.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and often fatal consequences of these problems through a wealth of research and information dissemination that includes the science and treatment fields and covers numerous stakeholders.

The organizational placement of substance abuse administrations within States varies. The Hughes Act (PL 91-616) required states to create a single State authority (SSA) to receive Federal funds. Currently, 30 States have an independent substance abuse authority separate from mental health. The remaining 20 States have combined substance abuse and mental health authorities into one umbrella agency.

SSA powers and duties recently have lessened in some States due to reorganization in State government, downsizing, and implementation of reform initiatives. In point of fact, the SSA is vital to the substance abuse policy framework because it is the lead State agency for developing and coordinating an integrated substance abuse prevention and treatment strategy. It is often the focal point from which Federal, State, and private funds are obtained and disbursed and, thus, assumes commensurate responsibility, accountability, and authority. Other SSA duties and roles include serving as purchaser of quality prevention and treatment services; overseeing planning and implementation of services at the local level, including technical assistance, training, and accountability; taking leadership in the development and dissemination of prevention and treatment best practices; and formulating a workforce development plan for prevention and treatment.

III. Understanding the Problem

A. TREATMENT PLANNING

CLIENT-FOCUSED TREATMENT. The base of knowledge about substance abuse has advanced significantly in the past two decades. Increasingly, substance abuse is viewed as a recurring, relapsing disease based on biological, psychological, and social factors. Providing treatment for such a complex disorder is difficult. To receive effective treatment, patients require access to a full continuum of client-focused services.

Due to the diversity among providers within the treatment system, it has been difficult to develop consistent approaches to treatment planning. Additionally, the roles, priorities, and views about substance abuse and treatment vary across systems and providers, leading to inconsistent approaches and standards for treatment regardless of setting. Many organizations in various systems (e.g., healthcare, mental health, social services) deal with individuals with substance abuse disorders on a daily basis and do so with different approaches; yet, all the care provided is considered treatment.

The result of the diversity of providers and patient populations (often coming from various referral sources) is inconsistent treatment approaches across the system. Just as the treatment approaches vary, so does the application of the existing treatment planning tools. This inconsistent application has had a negative impact on patient assessment procedures and, ultimately, on the ability of an organization to match a patient to appropriate care. When combined, these flaws in the treatment planning process result in poor retention and outcomes.

MATCHING THE CLIENT WITH THE APPROPRIATE TREATMENT. No single treatment approach or setting will be effective for all individuals in need of care. Treatment results often are linked to the ability of the program to address patient-specific treatment needs. The diverse and culturally segmented provider mix enhances the system's ability to provide gender and culturally sensitive care. Further, the emphasis on program-based care has made it easier to target specific communities or problems. However, this specialization also inhibits the ability of any single program to address all types of substance abuse, various stages of treatment, or specific client demographic and clinical characteristics. A significant number of clients are channeled into the programs that are available, rather than being directed to programs that would meet their individual needs.

To achieve optimal outcomes, providers should aggressively promote the concept of a continuum of care and provide access to alternative treatment approaches, settings, or services through inter-program or inter-system alliances and case management efforts. A positive correlation exists between effectively matching patients to treatment and treatment outcomes, emphasizing the importance of effective application of screening and assessment tools and outcome measures. A variety of tools have been developed over the years, but treatment providers often lack the resources or training to use available tools effectively. Further, the diversity of providers (with varying treatment approaches) has led to inconsistent application of the tools.

B. FINANCING AND REIMBURSEMENT

FINANCING. The most conservative estimates count at least 10 million to 13 million individuals in the United States in need of substance abuse treatment (see Panel I Report). This level of demand requires significant resources, both financial and non-financial. The adequate supply and effective use of resources are key elements to improving and strengthening the treatment system.

Only a small portion of services currently provided in the treatment system are covered by commercial insurance, whose set rates often are lower than rates for similar services (e.g., counseling) provided in other settings such as mental health or primary care. Thus, many programs that rely on Federal and State funding and charitable donations are inadequately funded.

According to a recent review of the field (IOM, 1997), the diverse financial structure of the substance abuse delivery system "involves a complex combination of public and private financing" that exacerbates the problems of fragmentation and inconsistency. "Public sector services are financed either with State and Federal appropriations or through Medicaid and Medicare coverage. Private systems of care have different structures but coexist and often overlap with public sector coverage."

Due to the lack of parity for substance abuse treatment in private as well as public insurance programs (i.e., Medicare/Medicaid), the public treatment system assumes major responsibility for funding care. Individuals are covered by specific public or private payors, and their ability to enter a specific program depends on that program's acceptance of the specific payor type. Individuals in need of treatment frequently cannot find programs of care that meet both need and payor criteria (the Panel I Report describes these problems in more detail).

REIMBURSEMENT. Providers have developed creative ways to use multiple funding sources to overcome the inadequacy of funding from any single source. However, the sheer complexity of reimbursement mechanisms (e.g., multiple funding sources, various rate-setting methodologies), hinders providers and States in maximizing available resources. For example, some States still do not include a general substance abuse treatment benefit in their Medicaid program.

Rates established by many payors fail to reflect the true cost of care or the margins that providers need to invest in resources and infrastructure. Providers often lack the resources to improve the infrastructure (e.g., management information systems to track client outcomes, staff training, billing systems) needed for better, more efficient care and to respond to increased demands for accountability. Furthermore, current reimbursement rates do not include the modest margins that providers need to access capital, retain staff, invest in new programs, and remain a financially viable organization. When combined, these problems create an under-funded system in which resources do not cover the cost of providing treatment.

MARKET FORCES AND THE IMPACT OF MANAGED CARE. The substance abuse treatment system is rapidly evolving in the same direction as the healthcare system, with reimbursement mechanisms and market forces driving changes in how services are financed and delivered. The emergence of managed care has affected programs organizationally, financially, and with regard to delivery of services. Currently, there are approximately 161 million individuals in managed care plans, accounting for 60 percent of the United States population (IOM, 1997). Like general healthcare services, managed care has had a strong and pervasive impact on the organization and delivery of substance abuse services, including restricting access through controlled use of services and predefined benefit packages, limiting panels of providers, and capitating reimbursement mechanisms.

Managed care has begun to focus attention on the measurement of outcomes, but also has placed emphasis on cost instead of patient needs. Public interest in quality of care in managed environments is high, and many purchasers desire research and data to help them make decisions on the value and effectiveness of different managed care options. Federal, State, and local governments, accreditation organizations, purchaser coalitions, consumer groups, professional organizations, the media, and managed care organizations (MCOs) themselves all are involved in defining, measuring and monitoring quality (IOM, 1997).

C. MANAGEMENT AND BUSINESS PRACTICES

Among the diverse providers in the treatment system, organizational leaders (both management and boards) possess varying skill sets. In some cases, this leads to organizations that do not operate on sound business practices or with strong leadership. To effectively operate in the changing environment, organizations will need to improve business practices and provide culturally sensitive services while meeting client needs. This will be a difficult task requiring a large investment by management teams.

As previously discussed, many treatment organizations have limited resources that hamper their ability to develop business strategies and infrastructures. Management teams frequently consist of individuals who have "grown up" in the system, who might or might not be those having the strongest business or management skills. Organizations often operate with insufficient staff and outdated management information systems. As the market shifts and reimbursement requirements change, they must now function in a more competitive environment than ever before. Many organizations will be unable to sustain existing operations without significant changes and improvements.

IV. Themes from the Public Hearings

To gain insight into community perspectives, CSAT held six public hearings around the country, hearing more than 400 testimonies from individuals from 31 states. They represented, among others, the recovery community, State and local agencies, treatment providers, educators, and researchers.

The issues that emerged at the public hearings supplemented and often echoed Panel member opinions. There were numerous testimonies on the need for a continuum of care that will allow better access to treatment, effective integration of overlapping systems throughout treatment, and increased availability of continuing and aftercare programs. Additionally, testimony was presented requesting that substance abuse expenses be reimbursed in the same manner as those for other medical conditions. Another major theme from the public hearings was that treatment programs should be better able to address the needs of special populations such as women, youth, seniors, and various ethnic groups.

Further issues that were raised included the need to:

- Address treatment within the managed care environment;
- Ensure high quality standards in the administration of treatment;
- Fund treatment programs based on client needs rather than program needs;
- Improve access to and availability of treatment services; and
- Increase communication between service delivery and research communities to ensure dissemination of best treatment practices.

The issues raised reflect community opinions and were considered as Panel members developed the recommendations.

V. Recommendations

The Panel identified three areas vital to improving and strengthening the treatment system: treatment planning; financing and reimbursement; and management systems. Treatment planning addresses the prevalence of program-based care rather than individual-focused treatment, and the importance of standards to monitor and improve quality and outcomes. The finance recommendation addresses insufficient reimbursement rates and the allocation of resources. Finally, the management recommendation addresses ways to improve the management and operations of organizations that function within or interact with the treatment system. Each set of recommendations builds on the work and recommendations of other authoritative groups that have conducted relevant examinations of these problems.

TREATMENT PLANNING

To address the issues that have resulted from the diversity of providers, inconsistent treatment approaches, and the difficulty in matching client to appropriate treatment, the Panel developed the following recommendation.

1. **Treatment plans should be based on an individual's needs and should respond to changes in need as he or she progresses through stages of treatment. Evidence-based practices should guide screening, intervention, assessment, engagement, individual and group therapies, aftercare, and relapse prevention so that the individual enters at an appropriate level of care, becomes engaged in services, and progresses through a continuum of care.**

Discussion

Panel members recognize the valuable contributions of the body of research on the organization and classification of treatment services. Moreover, they believe that implementation of a client-focused treatment model will promote needed changes in the substance abuse treatment system, including:

- A shift from program-based treatment approaches to client-based approaches that reflect individual needs and diagnoses;
- Standard indicators/protocols for client assessment and monitoring care; and
- Use of baselines/benchmarks to measure quality and outcomes.

The Panel believes that the development of a client-focused treatment model will improve and strengthen the treatment system. Specifically, the suggested model organizes and guides assessment of client needs, treatment interventions, and monitoring of performance. The model should incorporate treatment techniques that reflect cultural and other differences represented by clients. It comprises four components:

- Screening to identify major treatment needs;
- Intake/clinical evaluation and placement at the appropriate level of care;
- Treatment planning, engagement, and retention; and
- Continuing care.

The proposed model should reflect effective inter-system linkages, culturally competent services, and a broad range of care and services required. The model incorporates linkages with collateral systems of primary care, mental health, and social services. The anticipated result is improved inter-system communication and coordinated care. Ideally, a user-friendly and integrated management information system supports the model by monitoring biopsychosocial progress and providing feedback to clients, providers, managers, and purchasers.

The Panel feels that an important aspect of patient care is that substance abuse treatment include culturally competent services that consider communication and other specific needs of diverse populations requiring treatment. Treatment services should be provided in an environment responsive to the unique needs of the groups being served.

The model's purpose is to ensure that patients receive a full continuum of care appropriate to meet their needs. This recommendation includes identification and validation of the tools necessary to conduct assessment, planning, treatment, and monitoring processes. These tools (e.g., consistent screening, assessment, and placement indicators) have been proven effective, resulting in treatment services that are relevant for the population at hand and that match patients to the appropriate program and level of care. These tools also provide appropriate "interim criteria" for evaluating effectiveness and guiding application of specialized cognitive and behavioral interventions shown to improve treatment management, retention, and outcomes.

The Panel believes that although the modalities and settings for substance abuse treatment are commonly understood in general terms, there is a lack of understanding of the treatment process, that is, what occurs after someone enters treatment. Lack of a common understanding of the treatment process hinders development and use of appropriate client assessment and placement tools, treatment methods, quality improvement measures and processes, and client outcome and program performance measures and methods. It also contributes to the lack of understanding by the general public and some policy makers and payors concerning the effectiveness of treatment. Therefore, the Panel believes that a model treatment process should be defined that encompasses at least the elements illustrated in Figure III.3.

Development of a treatment model should be accompanied by and, in fact, might depend on, development of a taxonomy of treatment services.

To support this recommendation, the Panel feels that a taxonomy of treatment should be developed to provide a consistent description of substance abuse services. The taxonomy should serve as a framework for reimbursement and billing arrangements between purchasers and providers, in both the public and private sectors. It would also be beneficial in four areas:

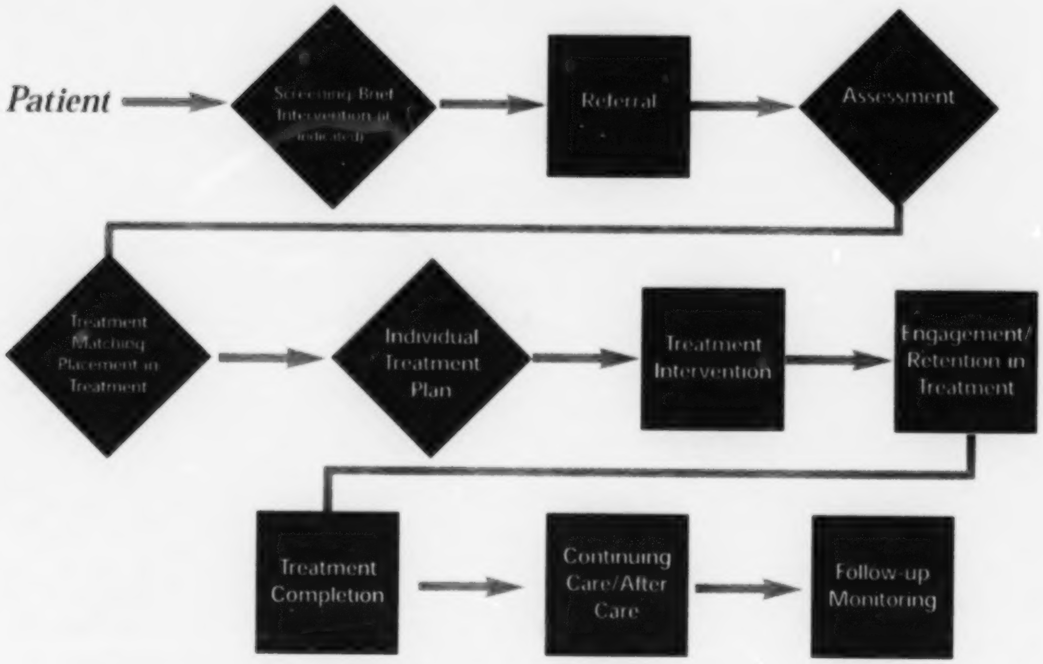
- *Communication* with the public — consumers, media, public policy officials, and purchasers of services — about types of substance abuse services available and how these services form a continuum of services.

- *Treatment Planning* to facilitate matching of patients with services appropriate to their needs and the evaluation of treatment outcomes.

- *Treatment Evaluation* by fostering precision in characterizing interventions and facilitating the synthesis of information from evaluations of treatment.

- *Reimbursement* by serving as framework for reimbursement and billing agreements between purchasers and providers, in both the public and private sectors.

Figure III.3. Treatment Process


Patient
Screening/Brief Intervention (if indicated)
Referral
Assessment
Treatment Matching Placement in Treatment
Individual Treatment Plan
Treatment Intervention
Engagement/ Retention in Treatment
Treatment Completion
Continuing Care/After Care
Follow-up Monitoring

*Screening, brief intervention, and referral might occur in a number of sectors outside the substance abuse treatment system such as the justice system, the school systems, the public health systems, the welfare system, and the workplace.

The Panel recommends that groups such as the American Society of Addiction Medicine (ASAM), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), CSAT, the Office of Applied Studies (OAS), NIDA, NIAAA, and others should be involved in developing the taxonomy.

The Panel examined numerous reports and studies that have addressed the need for improving treatment systems (see Selected Bibliography). The Panel's recommendation on treatment planning and, more specifically, on the development of a client-focused model in many ways encapsulates that body of previous work and sets a specific, practical agenda for producing the proposed changes.

Recommended Action Steps

The Panel suggests that after the release of the National Treatment Plan Iniative (NTP), CSAT should convene a group of national stakeholders to identify the tools, protocols, and practices required to facilitate and evaluate implementation of individualized programs of care. To support this and to promote the individualization of treatment, CSAT should analyze and compare current technologies for assessment, placement, treatment planning, and treatment implementation.

Panel members discussed and developed a series of activities that, if completed, will assist in the implementation of the recommendation. These activities include the following:

- State substance abuse authorities and other payors should phase in requirements for individualized treatment planning, recognizing that public and private systems of care must develop the capacity and infrastructure to support the adoption of these tools and practices.
- State accrediting and licensing authorities should incorporate requirements for individualized treatment planning into operational policies and accrediting standards.
- Treatment practitioners should be trained to implement individualized treatment planning and should use the tools and practices required to support the individualization of treatment.

FINANCING AND REIMBURSEMENT

Many community treatment programs struggle to survive because funding and resources are limited. Without adjustments in the level of reimbursement to support a full continuum of care, many providers may be unable to continue or simply will fall short of serving the community's needs (see Panel I Report). To address this problem the Panel recommends the following:

2. **Reimbursement mechanisms should be aligned with treatment goals and should incorporate performance measures and outcome standards to guide resource allocation, as well as rates sufficient to cover both reasonable costs and a surplus to support reinvestment.**

Discussion

This recommendation encourages a flexible approach to reimbursing treatment to address the undercapitalization of the treatment system. The current negative attitude toward profit within the treatment system makes it difficult for many organizations to compete in the market and effectively reinvest in their organizations. Combined with insufficient reimbursement rates, this attitude makes it nearly impossible for organizations to operate effectively or efficiently.

This recommendation takes a three-point approach aimed at addressing some of the problems of the current reimbursement system. First, it calls for the creation of a reimbursement system that aligns financing with desired clinical processes and outcomes. The revised system should account for variations in patient severity.

The second component of the recommendation is the establishment of rate-setting methodologies that account for total cost of treatment and infrastructure. A fair and equitable payment system might involve the sharing of risk so that reimbursement adequately covers costs.

The final component of the recommendation is to ensure that the reimbursement rate allows for margins after the base cost of services is covered. The Panel believes that this will have a positive impact on the quality of treatment, as providers are able to reinvest resources in programs, staff, and facilities. The strengthening of information systems and the infrastructure to support programs will enable organizations to compete in a managed care environment.

The substance abuse field has devoted much attention to the problems associated with financing substance abuse treatment. Although most previous recommendations were aimed at increasing or reallocating the amount of resources directed at the treatment system, this recommendation calls for adjustment of reimbursement rates (ASAM, 1995; IOM, 1998). The Panel's recommendation to realign reimbursement mechanisms with the goals of treatment clearly takes a new approach to revamping the structure of the finance system.

Recommended Action Steps

As the first step, the Panel believes that all payors should review and (where demonstrably justified) adjust their rate structure on an ongoing and regular basis, which should be no less than every two years. Further, CSAT should publish guidelines for establishing the true and reasonable costs of services.

MANAGEMENT SYSTEMS

The Panel acknowledges that treatment providers must operate in a cost effective and efficient manner. The Panel stressed that improving overall operational and financial performance of an entity will enhance its ability to serve a greater number of clients. Therefore, the Panel recommends the following:

3. **Treatment programs, payors, and regulators should promote organizational cultures that improve the quality, effectiveness, and efficiency of services through the adoption of best business practices for program management and operations. These should include effective governance and leadership for the board of directors and senior management; management and operation of human resources, marketing, and finance; information and data management operating systems; and capital and facilities.**

Discussion

As delivery of care becomes increasingly more business oriented, providers need to strengthen their management skills, resources, and operating infrastructure to compete effectively in the marketplace. This recommendation seeks to match the business skills needed for viability with the mission-driven values and the not-for-profit culture of treatment providers. The organizational culture should include improvements in the following areas:

GOVERNANCE AND LEADERSHIP. An organization's direction and ability to respond to market pressures on a timely basis are shaped by its governing body. In many instances, governing boards have evolved based on financial contributions or charitable interests of their members rather than on members' knowledge of the substance abuse treatment field or strong leadership skills. Successful provider boards should comprise members who possess strong management skills and industry knowledge. The organization's governance structure should reflect the community it serves. Included in this recommendation is the development of guidelines for establishing governing bodies, decision-making processes, and the training of boards that might be experiencing problems.

BUSINESS SKILLS DEVELOPMENT. Because of the changing times, many organizational leaders are not fully equipped to deal with managed care and other pressures. Often, individuals who serve as leaders of treatment organizations need to strengthen business management skills. It is essential in the increasingly competitive healthcare industry that management and boards of directors obtain necessary training for organizational management skills, financial planning, and effective allocation of resources.

This recommendation calls for the development of training programs and courses for organizational leaders. The courses should focus on developing management skills and changing the thinking regarding:

- Financial skills such as budgeting, reimbursement management and planning, capital requirements, and investment strategies; and

- Hiring and retention plans, allocation of resources throughout the organization, infrastructure development, facilities improvements, and general management.

The proposed training should be centralized and conducted nationally so that business practices and skill sets become more consistent across providers. The Panel recommends that CSAT leverage its existing initiatives, such as the National Leadership Institute (NLI), for this purpose. The NLI was established by CSAT to provide a learning environment in which community-based substance abuse treatment providers can share their expertise in management and business practices, while also building a new body of knowledge for the public treatment field. The NLI's mission is to help community-based treatment providers obtain business and management knowledge and technologies needed to successfully meet the challenges posed by the rapidly changing healthcare services delivery and payment environment. The NLI provides support to treatment providers primarily through technical assistance and training.

INFORMATION SYSTEMS. This recommendation also calls for the improvement of management information systems (MIS) to support clinical functions (e.g., treatment planning, client monitoring, and assessment of program outcomes) and management functions (e.g., budgeting, accounting, human resources) in addition to Federal and State reporting requirements. The systems should provide feedback to clients, providers, program managers, and purchasers, and where feasible, through automated means. Management systems must be accessible and user friendly and present data that are appropriate to the audience. The MIS also should be integrated to the greatest extent possible across the client encounter in support of the treatment model.

CAPITAL AND FACILITIES. Many facilities do not meet the standards mandated by the Americans with Disabilities Act (ADA) or accrediting bodies such as the JCAHO. Often the condition of facilities hinders the ability of providers to deliver treatment and reinforces the negative stigma of addiction, recovering individuals, and treatment itself. A clear problem is the inability of providers to access low interest loans or capital grants to fund new construction or renovation. This is due, in part, to providers' need for better knowledge of potential sources of capital as well as the precarious financial situation of treatment organizations that may preclude their obtaining loans.

The issue of capital includes facilities, but extends beyond to include other operational aspects of treatment providers such as MIS, which entail large capital expenditures. Other costs include providing transitional housing and transportation for clients, including the expense of vehicles and drivers. Providers need increased knowledge of financial resources, a greater understanding of how to tap sources of capital, and honed financial skills to facilitate their ability to obtain loans.

Few previous recommendations or reports have focused on management issues. One exception, however, is the longstanding focus on the importance of client-oriented data systems capable of both tracking clients through the continuum of care and analyzing data on costs (DHHS, 1998; Join Together, 1998). These recommendations, however, did not address the implementation process or the core elements needed to make the MIS functional. Consequently, the Panel recommends steps necessary to develop and implement a user-friendly, integrated information system.

Recommended Action Steps

The Panel believes that after the release of the NTP, CSAT should convene a representative group of various types of payors and stakeholders. This group should be tasked with defining goals of treatment and establishing performance standards and outcome measures. When completed, CSAT should make available to providers necessary training and support to implement these guidelines.

Panel members felt that to successfully implement the recommendation, CSAT and providers must emphasize improvement of business practices. Specifically, some recommended steps include the following:

- CSAT should develop a knowledge base and training for those provider organizations that need assistance in accessing capital to enable the critical access to capital and a stable and financially healthy provider community.

- CSAT, in collaboration with State substance abuse authorities and trade associations, should prepare and disseminate case studies illustrating the application of exemplary business practices for governance, leadership, human resources, marketing, finance, information management, and capital and facilities, inclusive of the potential impact that implementation will have on providers.
- CSAT should earmark a portion of its technical assistance resources, including the Addiction Technology Transfer Centers (ATTCs) and the NLI, for implementation and adoption of exemplary business practices in substance abuse treatment programs.
- CSAT, State substance abuse authorities, and trade groups should support the development and dissemination of training and educational materials to foster skill development for board governance, human resources, information management, and capital and finance.
- Substance abuse treatment organizations should examine their business infrastructure and upgrade systems and operations as necessary to conform with exemplary business practices. Because larger scale and more efficient operations often are required to support the necessary infrastructure for information and human resource management systems, it might be desirable to form cooperatives and networks or to merge to create larger organizations.
- Substance abuse treatment programs should monitor program outcomes, performance, and satisfaction and use that information to guide and improve program operations and service.
- Based on the efforts outlined in the prior action steps, providers should prepare and disseminate reports on program performance, productivity, and efficiency to payors, community, consumers, and staff.
- Substance abuse treatment programs should invest in staff development and training to ensure a culturally sensitive organization that values professional and business skills.

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Appendix
Profile of the Current System: Relevant Tables

Table III.1. Profile of Substance Abuse Treatment Facilities in the United States

Ownership	*Percent of Facilities*	*No. of Clients*	*Percent of Facilities*	*Organizational Setting*	*Percent of Facilities*
Private Nonprofit	59.8	<15	23.9	Specialty SAT	54.4
Private For-Profit	23.5	15-29	19.9	Mental Health	21.1
State/Local Gov't	12.6	30-99	32.6	Physical Health	13.5
Tribal Gov't	1.4	100-299	18.1	Community	5.8
Federal Gov't	2.7	300+	5.6	Criminal Justice	5.1

Source: SAMHSA, Uniform Facility Data Set

Table III.2.
Services Offered

Percentage of Substance Abuse Facilities Offering Selected Services	
Individual Therapy	96.6
Comprehensive Assessment/Diagnosis	93.7
Group Therapy	91.7
Family Counseling	85.6
Aftercare	82.3
Relapse Prevention Groups	78.4
HIV/AIDS Counseling	75.5
Self-Help or Mutual Help Groups	71.3
Outcome follow-up	66.8
Combined Substance Abuse and Mental Health	66.5
Transportation	48.6
TB Screening	42.1
Employment Counseling/Training	40.7
Detoxification	25.6
Smoking Cessation	24.4
Academic/GED Classes	17.2
Childcare	12.9
Prenatal Care	11.7
Acupuncture	4.7

Source: Horgan and Levine (1998)

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Table III.3. Referral Source

Referral Source	Percent of Patients
Criminal Justice System	34.0
Self-Referred/Voluntary	21.3
Other Treatment Facility	11.6
Health/Mental Health Provider	9.4
Welfare/Social Service Agency	7.2
Family/Friend	7.4
Employer	4.5
Other	4.8

Source: Horgan and Levine (1998)

Table III.4. National Expenditures by Payor Type, Alcohol and Substance Abuse Treatment

Payor Type	$ Billions	Percent of Exp.
Client	1.1	9
Private	3.6	29
Medicare	1.0	8
Medicaid	1.9	15
Other Federal	1.7	13
Other State	3.3	26
Total	12.6	100

Source: McKusick, et al. (1998)

Report of Panel IV: Connecting Services and Research

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I. Executive Summary

Substance abuse research has contributed to the field's understanding of pharmacological, behavioral, psychological, and environmental factors in treating clients. As stated in the Office of National Drug Control Policy's (ONDCP) 1999 National Drug Control Strategy, "recent research in the area of pharmacotherapies and behavioral therapies for abuse of cocaine/crack, marijuana, opiates and stimulants . . . will improve the likelihood of successfully treating substance abuse." Equally important is alcohol addiction and the research efforts aimed at the treatment and prevention of alcoholism. Clearly, it is important that the field use research findings to develop effective, evidence-based practices and to set standards for the purpose of improving services and better serving clients.

Despite many advances in research, however, study findings are not making the intended impact on the service delivery community. As emphasized in the 1998 Institute of Medicine (IOM) Report, *Bridging the Gap Between Practice and Research*, there is great need for, and value in, "enhancing collaborative relationships between the drug abuse research community and the community-based treatment programs." In response to this gap, The National Treatment Plan Initiative Panel IV has made specific recommendations to successfully connect services and research.

For research findings to be used by service providers and for research to meet the needs of those providers, a true collaborative relationship between the service delivery and research communities must be established. Service providers (as well as other stakeholders, including the recovery community, payors, educators, and policymakers) must have ample opportunity to contribute to research through participation, and also through the generation of treatment and services research questions to be addressed by the national research agenda. Furthermore, researchers must have the opportunity to contribute to service provision, not only through publication in the professional literature, but by sharing findings in a structure and format that facilitates practical application.

Current efforts to bridge research and practice, although moving in the right direction, remain disjointed. Without a systems change, such fragmentation is likely to continue. A new structure should be developed that coordinates research and practice initiatives. The proposed new coordinating structure should enable and encourage efforts among the various players to increase the likelihood that research reflects providers' needs and that research findings have practical applications in service delivery. The system should support the essential participation from all relevant stakeholders in contributing to the treatment services research agenda while fostering an environment in which researchers and practitioners work together to achieve successful knowledge transfer and application.

Panel IV has developed a plan to create such an interactive system. The Panel recommends the establishment of a system designed to connect services and research (CSR system), which would be supported and maintained through the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The system should provide an ongoing structure to enable and encourage consistent communication and collaboration among service providers, researchers, and other relevant stakeholders. The system should focus on the interdependent functions of knowledge development, transfer, and application, and should have the responsibility for advising, overseeing, and reporting on the progress and efforts of its mission.

To ensure the success of the CSR system:

- Efforts should occur on the national, regional, and State/local levels.
- A national level panel should work to facilitate communication among the regional, State and local levels as well as among CSAT, the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and other Federal agencies.
- CSAT should enter into formal memoranda of agreement with NIDA and NIAAA to establish a clear understanding of roles and expectations in the development and operation of the system.
- The CSR system should be incorporated into the ONDCP National Drug Control Strategy as the focal point of the CSAT/SAMHSA response to Goal 3, Objectives 5 and 6.[1]

The ***knowledge development*** component of the CSR system should facilitate new research based on the concerns reported by providers and other stakeholders who will be active participants in this process. An objective is to ensure that much of the new treatment and services research undertaken will be responsive to the needs expressed by providers and other stakeholders for information regarding both effective and efficient service delivery strategies (e.g., clinical management, organization, and financing).

The ***knowledge transfer*** component of the CSR system should synthesize research results and disseminate information on evidence-based treatment practices, policies, and strategies likely to improve the effectiveness and efficiency of treatment for substance abuse. The system should also ensure that a broad range of resource materials are produced for a diverse set of providers and other stakeholders who affect the substance abuse treatment system, such as regulators, policymakers, insurers, purchasers, and academic institutions that can incorporate new services knowledge in curricula designed to train clinicians entering the field.

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[1] ***Goal 3:*** Reduce Health and social costs to the public of illegal drug use. *Objective 5:* Support research into the development of medications and related protocols to prevent or reduce drug dependence and abuse. *Objective 6:* Support and highlight research and technology, including the acquisition and analysis of scientific data, to reduce the health and social costs of illegal drug use.

The ***knowledge application*** component of the CSR system should make use of established interpersonal strategies (e.g., training, consultation, technical assistance, and innovative techniques to achieve implementation and infusion of recommended evidence-based practices). Those strategies and techniques should be used to enhance provider practices, may be seen as impacting policy and regulatory activity, and should themselves be the subject of study to advance our understanding of how best to facilitate knowledge application.

The ultimate goal of the CSR system would be to ensure that research findings in substance abuse treatment and services are both useful to the field and effectively infused into practice. It should be noted that there is currently much more emphasis placed on knowledge development and knowledge transfer efforts, and much less effort devoted to ensuring that service providers are able to obtain the technical and problem-solving assistance necessary to implement innovations. Therefore, the Panel believes that there is a particular need to focus on knowledge application strategies, beyond knowledge transfer and dissemination, to ensure that new practices are adopted effectively.

To achieve these objectives, CSR efforts need to be made at the national, regional, and State/local levels to facilitate widespread involvement of researchers, providers, State and local government, payors, and consumers in CSR activities, and to encourage the likelihood that those activities will enjoy the broadest possible support. The success of the CSR system will rely on coordinated leadership among CSAT, NIDA, and NIAAA.

The national CSR panel should have representatives from the service provider and research communities, State substance abuse authorities, CSAT, NIDA, and NIAAA. Participation from other relevant Federal agencies (e.g., Agency for Healthcare Research and Quality (AHRQ) [previously, the Agency for Health Care Policy and Research (AHCPR)], which has an important role in connecting services and research in the healthcare field) should be encouraged. However, because Panel IV's charge is focused on the issue of substance abuse, the responsibility for this effort should primarily fall with CSAT, NIDA, and NIAAA.

The Panel recommends that CSAT enter into formal memoranda of agreement with NIDA, NIAAA, and other appropriate Federal agencies regarding CSR efforts to ensure systematic, ongoing collaboration for the development and operation of the CSR system, and to clarify roles and expectations.

The CSR system would be responsible for advising, overseeing, and reporting on progress and efforts toward the mission of connecting services and research, and appropriately involving researchers, service providers, and all other relevant stakeholders in knowledge development, transfer, and application efforts. The national panel would be expected to issue an annual status report describing the effect, successes, and barriers of the activities of the CSR system (and the various stakeholders). The report should be addressed to the relevant Federal authorities, and should be made available as a resource to all relevant Federal, State, and local agencies; legislative bodies; the service provider community; and concerned organizations.

To ensure accountability, the CSR system should be incorporated into the ONDCP National Drug Control Strategy as the focal point of the CSAT/SAMHSA response to objectives to support the development and application of research around preventing or reducing drug abuse and dependence (Goal 3, Objectives 5 and 6). The CSR national panel will facilitate communication among the national, regional, and State levels and will promote coordination among CSAT, NIDA, NIAAA, and other Federal agencies. The CSR national panel should act under the general authority of the Department of Health and Human Services, with support and direction provided by the Director of CSAT. CSAT should have the primary responsibility for establishing and maintaining the CSR system.

II. Background and Understanding the Problem

Government funding for research on substance abuse and treatment has increased for more than 25 years. Many rigorous studies of carefully crafted substance abuse treatment components found to be effective have great potential for helping service providers serve their clients better. Yet, for a variety of reasons, these treatment practices are often not implemented in community treatment settings. Also, there are additional areas of study that need to be researched that could have a significant, positive effect on treatment outcomes.

The communication problem between the research and service provider communities is neither new nor unique to substance abuse. Although the field has made "great strides in research on the etiology, course, mechanisms, and treatment of addiction," there remain "serious gaps of communication. . . between the research community and community-based drug treatment programs" (IOM, 1998). For treatment to continue to improve and to take full advantage of the investment in research, a true collaborative relationship must be established between the service delivery and research communities. Providers and other stakeholders must have the opportunity to contribute to treatment and services research, not only through participation in studies, but also in generating treatment and services topics to be addressed by the national research agenda. Service providers, policy makers, and State regulators need to receive the products of research in a form that facilitates their implementation, application, and adoption. Technical assistance and other hands-on training techniques are necessary to successfully infuse research. Furthermore, it should be recognized that there are inevitable costs associated with changing administrative policies and treatment practices. State authorities and local providers will need financial assistance in adopting new practices on a broad scale (see Panel III Report).

Collaboration among the responsible Federal agencies will enable research and services to learn from and respond to each other. As recommended in the 1998 IOM report, "CSAT, NIDA, NIAAA, and AHCPR are the Federal agencies that should develop formal collaborations, where appropriate, to synthesize research, reduce the barriers to knowledge transfer, and provide updated information about drug and alcohol treatment strategies to purchasers of health care."

NIDA and NIAAA concentrate more on research and knowledge development, while CSAT focuses more on services and knowledge transfer and application efforts. To enable research and services to learn from and respond to each other, collaboration among the leading federal agencies is essential. A system that will facilitate this collaboration and ensure this kind of interaction needs to be established and is the major concern of this Panel report.

A. CURRENT INITIATIVES

In response to the 1998 IOM report, *Bridging the Gap Between Practice and Research*, CSAT, NIDA, NIAAA, and others have developed important programs and initiatives designed to increase communication between substance abuse treatment providers and the research community, including the following:

CSAT — CSAT initiated the *Practice/Research Collaboratives* (PRCs) program to organize networks of community-based substance abuse treatment providers, researchers, and policymakers. The intention of the PRCs is to develop the necessary infrastructure to increase interaction and knowledge in funded communities. As stated in the Guidelines for Application (GFA), providers and researchers involved in the PRCs are expected to be "full collaborators in the development of the research proposals, implementation of protocols, interpretation of data, and publication of results."

NIDA — The NIDA *Clinical Trials Network* program was developed to establish a research infrastructure to conduct multisite clinical trials of interventions such as testing the integration of new medications and behavioral interventions in clinical practice. Additionally, under its *Research to Practice* program, NIDA will support research to improve knowledge of how to move research-based drug abuse treatment interventions into clinical practice. Despite research on a variety of psychosocial, behavioral, and pharmacological treatments, many of these interventions are still not in widespread clinical use.

NIAAA — Knowledge development activities at NIAAA include the publication of *Improving the Delivery of Alcohol Treatment and Prevention Services*, a national plan for identifying the research needs in the field and focusing future research efforts in those areas. This report set forth a broad agenda for research in such areas as managed care, treatment access, treatment outcomes, treatment costs, prevention services, and the research infrastructure. On the knowledge transfer side, NIAAA, in collaboration with CSAT, has held a series of *Research to Practice Forums*, which bring together leading researchers with directors of public and private treatment centers and others in the field to discuss the latest research advances that should be incorporated into clinical practice. Interest expressed at the Research to Practice Forums has led to an additional development, a *Researcher in Residence Program*. Also, a joint NIAAA/CSAT effort, this program places research experts for brief periods of residence at participating treatment centers for the express purpose of facilitating the adoption of specific changes in clinical practice.

AHRQ — In 1997, AHRQ (formally AHCPR), launched its initiative to promote evidence-based practice in everyday care through establishment of 12 Evidence-based Practice Centers (EPCs). The EPCs develop evidence reports and technology assessments on clinical topics that are common, expensive, and/or are significant for the Medicare and Medicaid populations. With this program, AHRQ became a "science partner" with private and public organizations in their efforts to improve the quality, effectiveness, and appropriateness of clinical care by facilitating the translation of evidence-based research findings into clinical practice.

State Efforts — A number of States have demonstrated initiative and leadership in efforts toward provider-researcher collaborations. For example, in Iowa, four academic institutions are connected with State policymakers. In this model, three advisory panels act on internal, external, and executive levels to increase communication between research and practice. Another example is Connecticut's Academic Partnerships, which have been designed to develop and implement research and service planning initiatives relevant to substance abuse State policy and service topics. The principles behind this alliance are to collaboratively identify research projects, jointly develop and implement research proposals, disseminate results to partners and stakeholders, and promote ongoing dialogue between researchers and providers.

It should be noted that CSAT has several programs that provide knowledge about substance abuse treatment and related topics to treatment providers:

The *Addiction Technology Transfer Centers (ATTCs)* were established in 1993. By 1998 CSAT funded a network of 13 geographically dispersed ATTCs covering 39 States, the District of Columbia, Puerto Rico, and the Virgin Islands, along with a National Office to coordinate cross-site activities. Drawing from current health services research from NIDA and NIAAA and applied research from SAMHSA, the ATTCs develop and disseminate curricula and state-of-the-art addictions information through comprehensive education and training programs, work toward the upgrading of standards of professional practice for addictions workers in multiple settings, prepare practitioners to function in managed care settings, and stimulate educational providers to address addiction in academic programs for relevant disciplines. The ATTC programs address all elements of addiction treatment and recovery for addictions treatment and public health/mental health personnel, institutional and community corrections professionals, and other related disciplines. These programs are presented in traditional format as well as through a variety of innovative distance technologies and other models of dissemination such as the presentation of symposia/workshops/papers at national, regional, and State professional meetings, exhibit booths, newsletters, and Web sites.

The *National Leadership Institute (NLI)* was established to provide a learning environment in which community-based substance abuse treatment providers can share their expertise in management and business practices, while also building a new body of knowledge for the public treatment field. The mission of the NLI is to help community-based treatment providers obtain the business and management knowledge and technologies needed to successfully meet the challenges posed by the rapidly changing health care services delivery and payment environment. The NLI provides support to treatment providers primarily through technical assistance and training.

The *Knowledge Application Program (KAP)* was initiated in 1999 and provides for a comprehensive array of knowledge application activities designed to ensure that knowledge developed by CSAT grants, cooperative agreements and contracts is appropriately "packaged" and disseminated to targeted audiences in the substance abuse treatment field and related fields (e.g., criminal justice, and welfare). The program also provides for activities to encourage and support the adoption by the substance abuse treatment and related fields of best treatment practices.

B. WHY WE NEED A SYSTEM

The programs described in the "Current Initiatives" section, although clearly laudable, are nonetheless limited in scope and fragmented, and there are few existing efforts to establish linkages among relevant Federal organizations. The various Federal agencies have generally focused attention on their particular constituencies. Thus, NIH programs typically concentrate on the concerns of *researchers*, whereas CSAT programs focus on the concerns of service *providers*.

The Panel strongly endorses a systemic approach that would build on and support the independent efforts of all stakeholders, help to coordinate their efforts, and fill existing gaps that currently prevent necessary connections. The system should address the entire research process, including the development, transfer, and application of new knowledge, with a particular emphasis on the knowledge application component. Federal efforts have historically focused on research efforts and dissemination of research findings, but have had only limited involvement in knowledge application (i.e., the implementation and adoption of treatment components found to be effective).

A system that can address the entire spectrum of knowledge development, transfer, and application would create opportunities to multiply the effect of various efforts by individual agencies or groups. It would support and enhance the efforts of researchers and service providers alike to ensure that new research is focused on appropriate subjects and that evidence-based practices are developed and effectively adopted by the field — a crucial element in improving substance abuse treatment. The Panel has proposed a framework for such a system, which is detailed in the "Recommendations" section of this Panel report.

III. Themes from the Public Hearings

Because a community perspective is vital to this effort's success, CSAT held six public hearings across the Nation to gather their input. More than 400 testimonies were heard from individuals from 31 states and included representatives from the recovery community, State, and local agencies, treatment providers, educators, and researchers.

Two main concerns emerged from these testimonies. First, many individuals expressed the need for a more effective and efficient method of disseminating research findings and outcomes data and, more specifically, to use those findings to identify the best treatment practices. Second, much testimony also focused on encouraging collaborations between community-based organizations and researchers that would result in funding and performing research that is relevant to the provider community.

Other needs expressed during testimony called for:

- Critical research area identification;
- Continuum of care; and
- Culturally sensitive treatment research.

The concerns raised during the public hearings reflect community opinions and were considered by the Panel members as they developed their overall recommendations.

IV. Recommendation

The Panel recommends the establishment of a system designed to connect services and research (CSR system), which would be supported and maintained through CSAT. The system should provide an ongoing structure to enable and encourage consistent communication and collaboration among service providers, researchers, and other relevant stakeholders. The system should focus on the interdependent functions of knowledge development, transfer, and application, and should have the responsibility for advising, overseeing, and reporting on the progress and efforts of its mission.

To ensure the success of the CSR system:

- Efforts should occur on the national, regional, and State/local levels.
- A national level panel should work to facilitate communication among the regional, State and local levels as well as among CSAT, NIDA, NIAAA, and other Federal agencies.

- CSAT should enter into formal memoranda of agreement with NIDA and NIAAA to establish a clear understanding of roles and expectations in the development and operation of the system.
- The CSR system should be incorporated into the ONDCP National Drug Control Strategy as the focal point of the CSAT/SAMHSA response to Goal 3, Objectives 5 and 6.

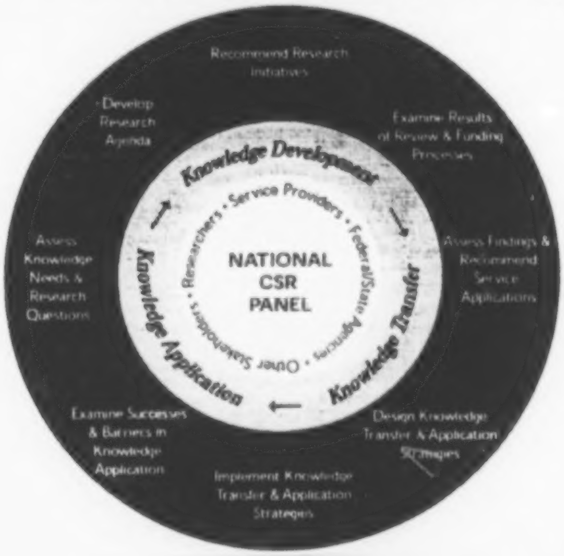
Guiding Principle of the CSR System

The guiding principle of this CSR system should be to involve service providers and researchers appropriately in mutually supportive ways throughout the development of the national research agenda, the conduct of research, and the application of evidence-based practices to improve service delivery. The CSR system should provide the structure and mechanisms necessary to connect the researcher and provider communities, working in conjunction with CSAT and the relevant research agencies.

Functions of the CSR System

A successful CSR system should allow treatment services research issues to emanate from the field and should also ensure that evidence-based practices are appropriately infused at the community level. It should promote the identification of treatment questions that need to be answered, the development of answers, the communication of findings to service providers, the application of findings, and the receipt of input from the field for revised and/or new research questions. The following diagram (Exhibit IV.1) illustrates the relationships among the knowledge development, transfer, and application parts of the CSR system.

Exhibit IV.1 Knowledge, Development, Transfer, & Application Cycle


Recommend Research Initiatives
Examine Results of Review & Funding Processes
Assess Findings & Recommend Service Applications
Design Knowledge Transfer & Application Strategies
Implement Knowledge Transfer & Application Strategies
Examine Successes & Barriers in Knowledge Application
Assess Knowledge Needs & Research Questions
Develop Research Agenda
Knowledge Development
Knowledge Transfer
Knowledge Application
Service Providers • Federal/State Agencies • Other Stakeholders • Researchers
NATIONAL CSR PANEL

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As illustrated by the diagram, the three knowledge areas should not be seen as separate processes, but rather as continuous and related throughout the cycle. The CSR system should ensure that the knowledge development process contains within it a consideration of how the research should ultimately be transferred and applied. Similarly, the knowledge application process should always include within it an evaluation component. That is, what is the outcome of the efforts to implement evidence-based practices at the local level? What do we learn about barriers as well as successful outcomes? How is this information incorporated into developing the continuing research agenda?

The nucleus of the cycle is the national CSR panel, which should include representation from service providers, researchers, Federal and State agencies, and other relevant stakeholders. This national panel would be responsible for guiding and overseeing the operation of the system throughout the knowledge development, transfer, and application cycle.

KNOWLEDGE DEVELOPMENT. It is crucial for providers to have the opportunity to have an active role in establishing the national treatment/services research agenda, so that the provider perspective can be adequately addressed in research studies. Innovative and promising strategies can then emanate from the treatment community and be subjected to appropriate study.

Furthermore, with appropriate attention given to the needs expressed by providers in the development of research agendas and the conduct of research, researchers will be better equipped to participate in the process of synthesizing and disseminating findings of maximum clinical importance.

The CSR system should be responsible for soliciting treatment issues and research questions from service providers and other stakeholders in the substance abuse treatment field, and for making recommendations to relevant funding agencies. The goal should be that service provider contributions acquired through the CSR system would be appropriately reflected in the research agendas of funding agencies through the program announcements (PAs) and requests for applications (RFAs) issued by these agencies. Specific knowledge development activities include:

- Assessing knowledge needs and research questions;
- Contributing to the development of the national treatment/services research agenda;
- Providing input to the development of research grant announcements; and
- Examining results of the grant review and funding processes to understand the extent tc which provider/stakeholder priorities and concerns are reflected in pending research.

KNOWLEDGE TRANSFER. This process ensures that research findings are communicated to service regulators, policy makers, and treatment providers in a structure and format that encourages understanding and use. Knowledge transfer and dissemination efforts to date include, for example, CSAT's *Treatment Improvement Protocol* series (TIPS) and the *Technical Assistance Publications* series (TAPS), *NIDA Notes* and *NIDA Therapy Manual* series, and NIAAA's *Alcohol Research and Health, Alcohol Alert,* and *Frontlines* series.

Building on such products, the CSR system should focus on designing and producing products to meet additional user needs, in particular, information products that are user-friendly and tailor-made to a wide range of audiences (including various types of clinicians, agency directors, policymakers, regulators, purchasers, and academic institutions). It is also essential that the knowledge transfer products developed are relevant to specific underserved populations and that questions of diversity are addressed.

The knowledge transfer component of the system should synthesize new knowledge, formulate policy and strategy recommendations relevant to improving the effectiveness of service delivery, and disseminate research findings and recommended practices to the treatment field. The system would be responsible for an annual review of findings from studies funded by CSAT, NIDA, and NIAAA performed in conjunction with these agencies. Based on that analysis, and working in conjunction with CSAT and the Institutes, appropriate findings should be transmitted to the field (including findings with regard to clinical practices, as well as management, organizational, and financial practices). Specific knowledge transfer activities should include:

- Assessing research to identify findings that could and should affect practices/policies;
- Synthesizing these findings and translating them into knowledge transfer products useful to all relevant audiences; and
- Assessing implementation of national and regional knowledge transfer strategies.

KNOWLEDGE APPLICATION. Historically, knowledge application has received significantly less attention than knowledge development and transfer. This complex function of knowledge application needs to be emphasized and understood to ensure the infusion of proven treatment interventions and approaches into general practice. Studies of knowledge transfer and application have demonstrated that circulating written materials alone achieves little in terms of adopting new technologies. For treatment clients to derive maximum benefit, evidence-based practices need to be absorbed into the broad range of community settings involved in substance abuse treatment. It should also be acknowledged that many community-based programs do not have the infrastructure or resources to take advantage of state-of-the-art dissemination approaches; innovative approaches need to be developed to address this problem.

Accordingly, the CSR system should have a strong focus on knowledge application efforts. Knowledge application should include a careful examination of the adoption process, what strategies facilitate application, and what barriers limit application of a recommended practice. Although much can be accomplished with existing knowledge application strategies, the capacity of more innovative techniques to encourage the use of evidence-based treatment practices needs to be fully realized. Different strategies should be studied to understand outcomes and to clarify the process of adopting new treatment practices with different groups and organizational structures.

To appropriately support the implementation of evidence-based practices at the State/local level, treatment interventions and approaches would first be identified as effective and appropriate for application through the annual review of study findings (described in the "Knowledge Transfer" section) to design effective strategies. The national CSR panel, in continuing partnership with the Federal agencies, would take responsibility for identifying barriers to adopting the evidence-based treatment components and for describing successful approaches to achieve implementation. Specific knowledge application activities include:

- Designing and implementing knowledge application strategies for evidence-based treatment interventions and approaches that are appropriate for adoption;
- Examining successes and barriers in knowledge application;
- Providing needed training and technical assistance; and
- Feeding lessons learned back into new research questions and new knowledge transfer and application strategies.

V. Discussion

A. THE CSR SYSTEM

To achieve its objectives, CSR efforts should be made at the national, regional, and State/local levels, with a structure facilitating communication among them. This will help to link all levels and ensure that decisions are not made only from the top-down. Also, this multilevel system will help to ensure that involvement in the CSR activities is widespread, encouraging the likelihood that those activities will enjoy the greatest possible support.

NATIONAL ROLE. Currently, CSAT, NIDA, and NIAAA each make important and distinct contributions to knowledge development, transfer, and application efforts. The goal of the CSR system is to better connect, support, and extend these efforts. Crucial to the establishment of an effective system is the coordination of activities among the CSR panel and these Federal agencies, as well as the system's capacity to receive and share information with all relevant stakeholders.

A national CSR panel would facilitate coordination among CSAT, NIDA, NIAAA, and other relevant stakeholders. The specific responsibilities of this panel should include developing research issues based on input from providers and other stakeholders to inform the national treatment research agenda; sharing treatment research findings with the service provider community to improve and increase client services; and periodically reporting on the progress of collaborative knowledge development, transfer, and application efforts to the Directors of CSAT, NIDA, and NIAAA, as well as other relevant agencies.

To achieve the needed cooperation, Panel IV recommends that the Director of CSAT, in collaboration with the Directors of NIDA and NIAAA, appoint the Chair (who would not be a Federal Official) and the members of the national CSR panel. Membership should be based, in part, on an equal number of nominations from CSAT, NIDA, and NIAAA of their grantees as well as representatives from the service delivery and treatment research fields and from the Single State Agencies, up to a maximum number of 15 panel members. Representatives from the service delivery field would constitute a minimum of 50 percent of panel members. The Directors of CSAT, NIDA, and NIAAA, or their designates, would serve as ex officio panel members. A representative from the DHHS Office of the Secretary, from ONDCP, and from AHRQ should also be included as ex officio members. Other stakeholders (e.g., NASADAD, State substance abuse authorities, substance abuse treatment professional organizations, other DHHS agencies and other Federal agencies) should be called on to participate in the panel deliberations as needed, for example, through subcommittees established by the national CSR panel.

Additionally, the Panel recommends that CSAT enter into formal memoranda of agreement with NIDA and NIAAA regarding CSR activities to ensure systematic, ongoing collaboration for the development and operation of the CSR system, and to establish a clear understanding of roles and expectations.

To ensure its accountability, the CSR system should be incorporated into the ONDCP National Drug Control Strategy as the focal point of the CSAT/SAMHSA response to Goal 3, Objectives 5 and 6, which address the need to base effective treatment on research findings. Goal 3, Objective 5 is to "support research into the development of medications and related protocols to prevent or reduce drug dependence and abuse." Objective 6 is to "support and highlight research and technology, including the acquisition and analysis of scientific data, to reduce the health and social costs of illegal drug use" to ensure that "federal, state, and local leaders [are] given accurate, objective information about treatment modalities" (ONDCP 1999 National Drug Control Strategy). The CSR system should be built into the *Performance Measures of Effectiveness* system (PME) currently being developed and implemented by ONDCP to assess the performance of the National Drug Control Strategy. In this way, the CSR system will be held publicly accountable through the ONDCP National Drug Control Strategy reporting process.

REGIONAL ROLE. Whereas the national panel should work at a macro-level, most of the needs assessment and knowledge application work should be conducted at the regional and State/local levels. Regional-level efforts should facilitate the flow of information about new strategies from the national level to the field and should also help to communicate the needs of the field to the national level.

The ATTCs and other existing programs should play a significant role in the CSR system at a regional level. Consideration should be given to modifying the responsibilities of the ATTCs to allow them to play a substantial facilitative role to identify topics for research and to develop and conduct knowledge transfer and application.

Specifically, regional efforts should:

- Create a mechanism to ensure participation from providers, researchers, State agency officials, representatives from the CSR State level, and other relevant stakeholders;
- Classify the data collected from the States with regard to research identified as significant in the region;
- Provide support to the States in the development of State panels or other such mechanisms;
- Develop knowledge transfer products and application strategies for implementation at the regional, state, and local level to improve outcomes. These products should be "hands-on" and usable by the entire range of community-based providers;
- Coordinate knowledge transfer and application activities; and
- Help determine the success of application efforts and problems in implementation.

In addition to providers, it is essential to include State agency officials, researchers, and other appropriate stakeholders drawn from their respective regions.

STATE ROLE. States play a critical role in the financing and management of substance abuse service systems, as well as in the promotion of quality care. Part of the State's role in establishing a successful CSR system should be to ensure that local providers are involved in the work of the system and have the opportunity to contribute to the treatment/services research agenda and participate in the conduct of the research. Local providers and relevant stakeholders should be contacted to develop possible research topics.

States should also be responsible for providing leadership to implement knowledge transfer and application strategies. State agency officials should provide financial incentives and assistance to the effort to implement treatment research findings and strategies, and should involve providers, researchers, and other stakeholders in the particular State, under the leadership of the State substance abuse authority. These efforts should be geared toward the full range of expertise among community-based providers.

A number of states currently support research and data collection efforts and/or have training programs in place for the substance abuse service providers in their State. By building on these already existing activities and the ongoing relationships they have with their provider systems (contractual, regulatory and otherwise) States are in a position to contribute significantly to the success of the CSR system.

State service provider associations also exist in many States that are in a unique position to contribute to the success of the CSR system, both to identify research questions and as a mechanism for knowledge transfer and application.

CSR REPORTING RESPONSIBILITY. The CSR national panel will issue an annual status report describing the effect, successes, and barriers of the activities of the CSR system. The report should address the effectiveness of the knowledge transfer and application process with particular emphasis on the degree to which specific innovations were actually adopted into clinical practice. The purpose of this report is to hold the CSR system accountable for making a difference in successfully connecting services and research and to encourage modifications or improvements to the system where warranted. The chair of the CSR national panel would be responsible for the issuance of that report. The report should specifically address:

- Efforts by the CSR system to obtain research topics and promising treatment interventions appropriate for research from service providers and other stakeholders;
- The extent to which the topics and interventions identified are actually expressed by the research initiatives (e.g., PAs and requests for proposals (RFPs) undertaken by CSAT and the Institutes;
- CSR efforts, in conjunction with CSAT and the Institutes, to identify and select research-based treatment interventions appropriate for application;
- Efforts to develop knowledge transfer strategies that make findings readily available and accessible to service providers and other relevant stakeholders;
- Efforts to develop knowledge application strategies to achieve the adoption of those treatment interventions and address and overcome barriers to adoption; and
- The extent to which research-based treatment interventions are adopted by service providers.

The report will provide information to CSAT for its reporting to ONDCP on progress toward meeting the relevant research and knowledge transfer goals and objectives of the National Drug Control Strategy (i.e., Goal 3, Objectives 5 and 6). Additionally, the report should be addressed to the other relevant Federal authorities, and should be made available as a resource to Federal, State and local agencies, legislative bodies, the service provider community, and concerned organizations. Clarification and elaboration of report findings should be provided to recipients of the report as necessary and appropriate. In this way, the CSR system should be able to act as a resource for credible information from the field regarding the capacity for the treatment community to benefit from research conducted, and to contribute to the course of future research.

B. PROPOSED VISION OF IMPLEMENTATION

The CSR system should be responsible for performing specific activities to accomplish its mission and proposed implementation plan, which are detailed in this section and are illustrated by the knowledge development, transfer, and application cycle diagram shown previously. Panel IV proposes the following plan as a guide for implementing the CSR system. The Panel recognizes the need for flexibility in building the system.

1. KNOWLEDGE DEVELOPMENT

Assess Knowledge Needs and Research Questions

The CSR system should encourage the development of research studies that focus on the treatment questions that are posed by service providers and other stakeholders in the course of contemporary service delivery. This goal will be accomplished by creating a mechanism that invites opinions from service providers to the national treatment/services research agenda.

Service providers will be solicited for their concerns regarding service delivery. In addition, there can be important and innovative strategies practiced by treatment providers (e.g., successful partnerships between substance abuse treatment providers and housing unit programs) that are currently not being communicated to the research community. It will be the responsibility of the CSR system to provide essential linkages between members of the research and service delivery communities to permit significant issues and promising approaches to be incorporated into the eventual research agenda.

The CSR system should also encourage studies conducted within typical treatment settings to increase the practicality and generalizability of the findings from research. CSAT, related Federal, State, and local agencies, and private agencies should support both treatment development (focused on developing new therapies, treatment practices, and medications) and health services research (focused on access, effectiveness, outcomes, financing, and organization, and their relationship to public policy) within "real world" treatment organizations. This "real world" context should include both urban and rural treatment programs, as well as diversity-related topics (e.g., gender-specific and cultural competency concerns). Every effort will be made to achieve research goals without creating major disruptions in the existing treatment process of these programs.

Develop Research Agenda

The CSR system should ensure that a broad representation of providers and other stakeholders and disciplines is included in the development of the national treatment/services research agenda.

The CSR system should conduct a formal needs assessment that identifies the questions of greatest relevance and importance to the substance abuse treatment field. These questions will be recommended as subjects to be addressed by the research initiatives of funding agencies (e.g., NIDA, NIAAA, and other Federal agencies that might conduct relevant research). The system will also inform itself regarding programs funded by those agencies and of research programs planned in order to make certain its recommendations do not duplicate ongoing or planned activity. The CSR national panel should convene at least one meeting each year to seek out knowledge needs expressed at the State and regional levels and to review agency activities. This information will be used to develop the research agenda, and in this way, the CSR system will ensure that service providers and other stakeholders will have the capacity to identify areas of importance not being studied or planned for study in the research agenda.

As described previously, treatment providers can affect research by identifying important treatment issues and promising treatment approaches from the field. Provider, State agency, and other stakeholder input can also include systematic feedback on the effectiveness of knowledge transfer and application strategies, as well as identify barriers to the application and use of evidence-based treatment approaches.

Recommend Research Initiatives

The CSR system will encourage research funding agencies to emphasize the importance of researcher-provider collaborations in research initiatives issued. Specifically, the CSR system should work to ensure that Federal, State, and local funding agencies (public and private) provide the financial resources and manpower required by treatment programs to support the collaborative research efforts. The CSR system should also develop recommendations for Federal funding agencies on how to incorporate information from service providers and other stakeholders into their research agendas as reflected by the PAs, RFAs, and RFPs issued by these agencies.

There should be a continuing investment in demonstration research programs, which would permit a mix of funding for research and for service delivery in support of that research. These demonstration research programs would permit the development of treatment models for testing in community settings, and permit greater collaborative efforts between researchers and service providers.

An example of a potentially useful demonstration research area might involve the subject of group counseling. Although we have information indicating that group counseling is the predominant treatment component, we do not have a delineation of the group strategies used and possess virtually no information on the effectiveness of different strategies or of their effectiveness compared with individual counseling.

Examine Results of the Review and Funding Processes

The CSR system will regularly examine the results of research grant/contract awards to assess progress in meeting the goals of linking the research and provider communities and incorporating provider concerns in approved and funded study. To that end, the system will work with CSAT, NIDA, and NIAAA to ensure their respective capacities to hear and incorporate the needs and concerns of the treatment community into their research agendas. This will be done by: (1) assessing and reporting treatment research obtained from the provider community; and (2) encouraging that PAs, RFPs, and GFAs reflect, to the extent possible, that provider input. Finally, there should be a periodic assessment of the extent to which provider concerns are actually reflected in approved and funded programs (i.e., the effectiveness of the CSR process).

2. KNOWLEDGE TRANSFER AND APPLICATION

Assess Research Findings and Recommend Service Applications

The CSR system will work with CSAT, NIDA, and NIAAA to assess the findings developed from those organizations' research and knowledge development efforts, and to recommend evidence-based practices for field application. Annually, CSAT, NIDA, and NIAAA will be asked to review their research findings on evidence-based practices and nominate candidate treatment protocols to use in the field. The CSR national panel will then work in conjunction with CSAT and the Institutes to determine which evidence-based practices should be implemented in treatment settings. The following steps are examples of what *might* be undertaken:

- The national CSR panel works with CSAT, NIDA, and NIAAA to establish essential criteria to select evidence-based practices (e.g., robust research findings and feasibility regarding cost and personnel required).
- The national expert panel solicits nominations from the Federal agencies for evidence-based practices appropriate for dissemination and implementation.

- The national CSR panel reviews practices nominated for generalizability regarding both the affected populations and the issues addressed, practicality, judgment as to cost effectiveness, and cultural relevance.
- The national expert panel receives information from the regional and State/local levels regarding priorities and potential barriers (i.e., the list goes to the localities for review, and comes back both prioritized and with an indication of what barriers might be experienced).
- Based on this information and a careful analysis of potential barriers to implementation, selections for evidence-based practices to be disseminated and used are finalized and a strategy for application is developed.

Design and Disseminate Knowledge Transfer Products

With specific regard to knowledge transfer (i.e., information sharing), the CSR system will help to ensure dissemination of research findings, working with and through CSAT. This involves the translation of research findings into useful products that are relevant to State and local providers and the transfer of this information through, for example, manuals or other written materials, the use of electronic techniques including websites, and knowledge sharing conferences. A product that provides a taxonomy of evidence-based practice models that can be disseminated to the field biannually should be considered.

It should be acknowledged again that CSAT, NIDA, and NIAAA all currently produce these information products. However, a major obstacle to overcome in adopting new knowledge is that research results are often communicated in language appropriate for academic discourse, but not in a style useful to treatment staff. Therefore, the CSR system will work to ensure that (a) knowledge transfer products are tailored to suit an entire range of treatment providers with varying levels of research knowledge, and (b) appropriate training and technical assistance are available.

A broad range of materials should be produced for other stakeholders that impact the substance abuse treatment system, such as regulators, policymakers, insurers, purchasers, and educators who can incorporate new services knowledge into curricula designed to train existing personnel and students preparing to enter the field.

Design Knowledge Application Strategies

Many knowledge transfer products and services currently exist, but their counterparts in knowledge application (to ensure implementation and adoption of innovations) are far less in evidence. Less effort has traditionally been devoted to ensuring that service providers are able to obtain the technical and problem-solving assistance necessary to implement innovations.

Therefore, knowledge application strategies must go beyond knowledge transfer to ensure that new practices are effectively adopted in the field. Here, the additional use of workshops, consultation, training, and other strategies is needed. Again, it is critical to be aware of the needs and the nature of the target group in order to ensure that the knowledge is deemed useful and appropriate. In addition, it will be critical to receive feedback regarding how that knowledge is used and to learn the nature and degree of organizational change achieved.

Through the CSR system, assessments will be made of the effectiveness of different application strategies and of different reward systems (e.g., use of formal recognition, continuing course credits, financial incentives for program achievement). Additionally, the regions and States will be asked to conduct a careful analysis of any barriers to implementation and to make suggestions for promoting the practical application of the selected new evidence-based practices. The field review will also help ensure that the needs for cultural, geographic, and other adaptations on the local level are addressed.

It should be emphasized that the CSR system will have effective strategies to achieve knowledge application available to it immediately. Specifically, research conducted with typical substance abuse treatment programs has demonstrated the capacity of interpersonal knowledge application strategies (i.e., workshop and consultation models) to achieve the adoption of novel treatment components (Hall, Sorensen, and Loeb, 1988; Sorensen, Hall, Loeb, Allen, Glaser, and Greenbey, 1988). Thus, knowledge application strategies are now available to further increase the capacity of treatment programs to respond effectively to client populations. The CSR system described provides an opportunity to use those existing strategies and to understand the effectiveness of additional strategies of knowledge application. The CSR system will identify successful knowledge application and adoption strategies that address regulatory, financing, administrative, and supervisory matters, as well as practitioner skill.

Implement Knowledge Transfer and Application Strategies

After the national CSR panel determines the products and strategies appropriate for successful dissemination and application of the selected evidence-based practice, the proposed action plan (tools and methods) might be submitted for a time-limited field review at the regional and State/local levels. This would ensure that all stakeholders have the opportunity to contribute to the action plan.

The structure of the CSR system can be particularly useful to the process of achieving knowledge transfer and application. As described previously, having participation from the regional and State/local levels in the process of selecting treatment components for transfer based on their needs and interests, more likely assures the receptivity of local providers to new knowledge and treatment techniques.

By having the regional level association of the ATTCs as part of the overall system, there is the potential to develop and/or refine knowledge transfer and application strategies that are particularly well-suited and appropriate to the needs of that region and its States.

With involvement from the State in the overall system, there is the potential for having the local structure and resources needed to facilitate the process of knowledge transfer and application in those areas the local providers have defined as significant to their functioning. Thus, just as the CSR system is structured to permit comments from service providers and other stakeholders regarding their needs and concerns to the development of the national research agenda, the CSR system is also structured to ensure the transfer to service providers of that knowledge and those newly available techniques that are most appropriate to their needs and concerns.

Examine Successes and Barriers in Adoption

The CSR system will also include an evaluation of the efforts made to achieve knowledge transfer and application. The system will evaluate the adoption of research-based innovations and dissemination strategies, including feedback from practitioners to learn how easily and effectively the innovations were adopted into treatment practices. The CSR system will be responsible for seeking information from the field regarding the enhancement of client treatment with the adoption of new practices, and regarding the barriers, if any, that made the adoption difficult or impractical. By studying the successes and barriers to adopting innovations into treatment settings, new and/or revised topics may also be fed back into the research agenda.

Additionally, the CSR system could contain a recognition program. The purpose of this program would be to acknowledge and reward researchers, policymakers, and providers for their contributions to the improvement of treatment services. Recognition of contributions to the improvement of treatment services is both warranted and can act as an incentive to recipients and to others in the substance abuse treatment field. For example:

- Researchers should be acknowledged for developing and helping to implement significant evidence-based practice initiatives.
- Policymaking groups should be recognized for their roles in facilitating and helping to institutionalize evidence-based practices.
- Providers and other entities such as managed care organizations should be rewarded for special achievements in the implementation of evidence-based practices.

C. CONCLUSION

The CSR system is designed to be comprehensive and to provide the needed linkage between the service provider and the researcher, such that the researcher receives the benefit of input from the service provider regarding the provider's needs and concerns, and the service provider receives information from the researcher in a format and structure that facilitates practical application of findings on behalf of the client population to be served. The CSR system, organized and maintained in conjunction with CSAT, would: (a) facilitate input from State and local providers to the creation of the national services research agenda, and (b) support the development of knowledge transfer and application strategies to ensure that the accomplishments of research have the widest possible application.

Most importantly, by developing a system to enable the service delivery and research communities to work together more productively, the needs of the client community can be best addressed, and substance abuse treatment can be made still more effective.

VI. Selected Bibliography

The sources listed reflect those used by the panel members based on the data current at that time. Subsequent sources were not incorporated into the individual reports, but may be in the companion report, *Changing the Conversation, Improving Substance Abuse Treatment: The National Treatment Plan Initiative.*

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Report of Panel V: Addressing Workforce Issues

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> *Substance abuse treatment providers are "responsible for adapting to changing realities that affect where they work, what skills they will need on the job, how they can best provide the services, who they work with, and even the philosophical underpinnings that guide their efforts. It is the workforce that must be recruited to provide needed services. It is the workforce that must be trained to provide the types of services that are being put into place. It is the workforce that must often meet special certification and accreditation requirements. And it is the workforce that is ultimately responsible for supporting the individual growth and development of the people who are receiving . . . . health services" (Fazzi, 1990).*

I. Executive Summary

Fazzi (1990) identified recruitment, training, certification, and accreditation requirements as key issues related to workforce. In line with this approach, the Workforce Issues Panel (the Panel) members identified current workforce topics causing concern, and organized these within three issue groups: (1) Education and Training; (2) Credentialing; and (3) Supply, Demand, and Distribution.

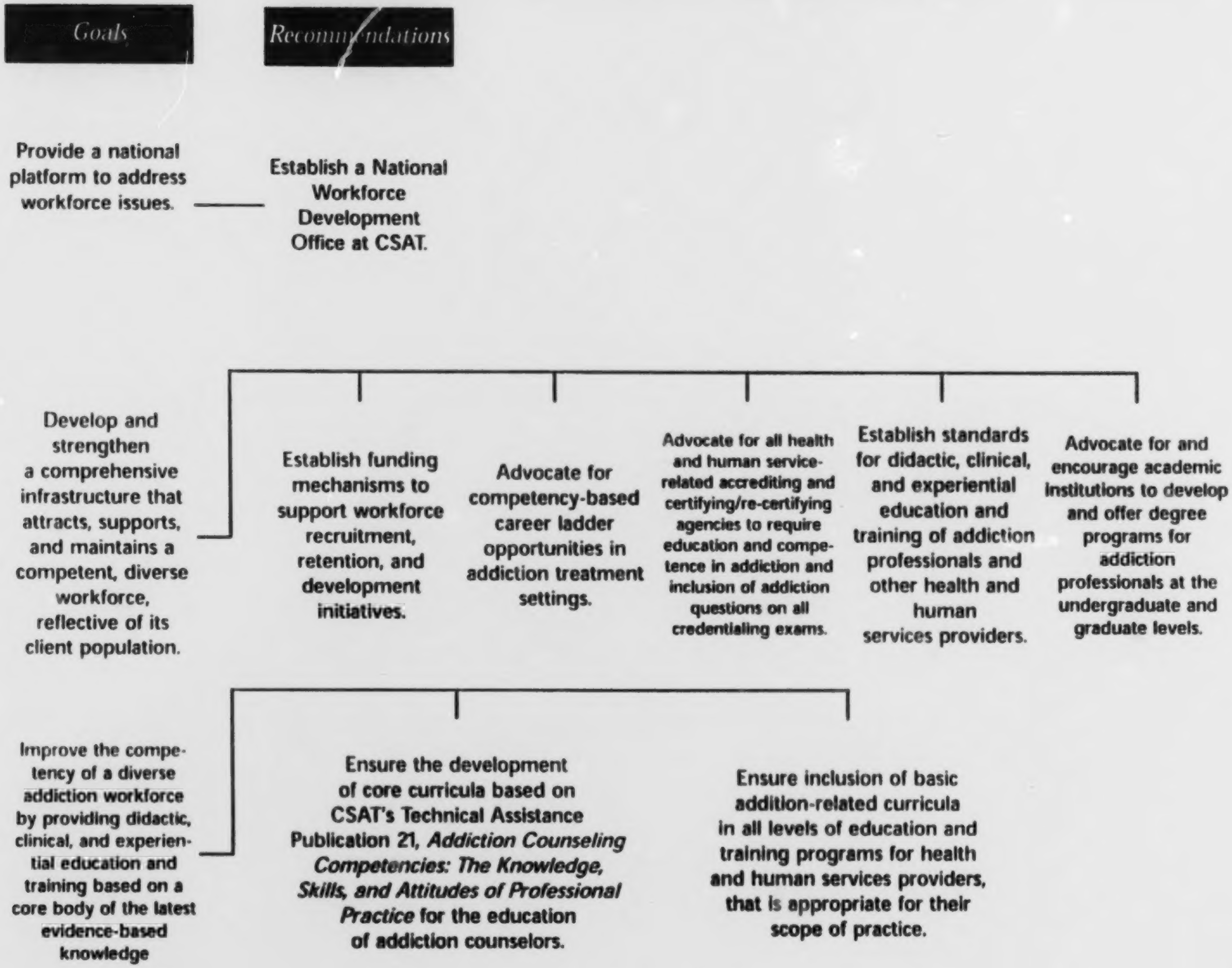
The objective of professionals to guarantee universal delivery of optimum standards of care, together with the recent connection between provider reimbursement and education levels, call for a formal strategy and defined standards for educating and training substance abuse treatment staff. However, currently there is no consensus on the best approach to educating and training the substance abuse treatment workforce. Moreover, the lack of categorical funding for education and training impedes the work that can be done to address this at a system level and at a program level. The variety of educational backgrounds that staff bring to the field dictates an approach to basic and continuing education that is widely applicable. The changing patient population, the introduction of managed care, as well as other environmental and policy changes introduce substantial complexity.

The Panel recognizes the compelling need to integrate the variety of approaches to substance abuse counselor credentialing that currently exist. Credentialing processes employed in other professions whose members practice in healthcare (e.g., nurses, physicians, social workers) exacerbate this diversity of approaches, as do those employed in professions whose members are credentialed for practice by their own profession but might also have a specialty credential in addiction. Clearly, the field needs a more cohesive and unified approach to credentialing.

Inadequacy of quantitative workforce data to inform discussion severely hampers analysis of supply and demand. In addition to a lack of general and specialist skills, there is anecdotal evidence of a shortage of staff with administrative skills, staff with an understanding of the substance abuse system, and staff who work in research and/or academic settings. Furthermore, the increasing ethnocultural diversity in the treatment population calls for a workforce that is ethnically and culturally diverse and sensitive to the cultural concerns of different client groups.

The recommendations of the Center for Substance Abuse Treatment (CSAT) National Treatment Plan Initiative (NTP) Workforce Issues Panel address all three core issue groups, with the intent of bringing the substance abuse treatment field closer to the Panel's vision of the future, as delineated in the Analysis section. Presented in Figure 1, the recommendations fall into three types: (1) those that address the need for a Federal agency, with responsibility for workforce-related issues such as education and development; (2) those that seek to strengthen the workforce infrastructure in the substance abuse treatment system, (e.g., workforce strategies, policies, and procedures); and (3) those that require implementation at a field and/or program level.

Figure 1. Goals and Recommendations of the Workforce Issues Panel



Provide a national platform to address workforce issues.

- Establish a National Workforce Development Office at CSAT.

Develop and strengthen a comprehensive infrastructure that attracts, supports, and maintains a competent, diverse workforce, reflective of its client population.

- Establish funding mechanisms to support workforce recruitment, retention, and development initiatives.
- Advocate for competency-based career ladder opportunities in addiction treatment settings.
- Advocate for all health and human service-related accrediting and certifying/re-certifying agencies to require education and competence in addiction and inclusion of addiction questions on all credentialing exams.
- Establish standards for didactic, clinical, and experiential education and training of addiction professionals and other health and human services providers.
- Advocate for and encourage academic institutions to develop and offer degree programs for addiction professionals at the undergraduate and graduate levels.

Improve the competency of a diverse addiction workforce by providing didactic, clinical, and experiential education and training based on a core body of the latest evidence-based knowledge

- Ensure the development of core curricula based on CSAT's Technical Assistance Publication 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* for the education of addiction counselors.
- Ensure inclusion of basic addition-related curricula in all levels of education and training programs for health and human services providers, that is appropriate for their scope of practice.

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II. Background and Understanding the Problem

The introductory quote by Fazzi powerfully conveys the crucial role of the substance abuse treatment workforce as well as the importance of workforce policies in the delivery of quality treatment services. The substance abuse treatment workforce presents multiple issues and challenges, which have rarely, if ever, been addressed as a whole. Many groups and individuals have undertaken excellent work on individual aspects of the substance abuse treatment workforce; however, the complexity of issues and the number of agencies in contact with individuals with substance-related disorders require a more holistic approach. Establishment of a Panel to address workforce issues provides the substance abuse treatment field with an opportunity to undertake the first comprehensive, qualitative analysis of substance abuse treatment workforce issues and to present recommendations that can serve as an agenda for improving the workforce in the twenty-first century.

The substance abuse treatment workforce includes a wide array of practitioners and lay persons who care for clients with a range of substance abuse problems, in a variety of settings. Psychiatrists and other physicians, psychologists, nurses, social workers, counselors, marriage and family therapists, individuals recovering from a substance related-disorder, clergy, and many others are involved in client interventions.

The degree to which professional staff are educated in substance abuse treatment differs from one discipline to another. Requirements for substance abuse treatment credentialing also vary from one discipline to another. The diversity of educational backgrounds within this workforce, as well as the diversity of client needs, creates a unique challenge to the substance abuse treatment field in its efforts to develop workforce policies and procedures consistent with established healthcare professions. Furthermore, policy decisions on credentialing requirements, opportunities for further education, professional development, and the existence of a professional career ladder affect the number and quality of staff in a given healthcare field. Therefore, the specifics of workforce policies and procedures will have a far-reaching impact on the supply of (and, therefore, demand for) workforce in the substance abuse treatment field.

For the purposes of this report, the substance abuse treatment workforce is defined as practitioners in a variety of related disciplines (e.g., counselors, physicians, nurses, psychologists, social workers with varying levels of education, training, experience and credentialing) who intervene in the lives of people with substance use disorders.

The Panel considers good substance abuse treatment to be a function of the following workforce characteristics:

- Quality — education, training, credentialing, experience (type and length);
- Quantity — supply and demand, staff distribution, client-staff ratio;

- Social characteristics — cultural congruence, cultural competency;
- Practice — competence consistent with continuum of care, client experience, client needs, and environmental context.

The challenge for the Panel was to develop recommendations that: (1) protect and enhance the supply of staff; (2) establish and apply cross-disciplinary practice standards for competency development, continuing education, training, and credentialing that protect client interests, satisfy the demands of payors, and address the interests of staff; and (3) recognize and preserve the diversity of staff background.

The Panel structured its work on workforce issues within the core issue topics of Education and Training; Credentialing (including licensing and certification); and Supply, Demand, and Distribution. Although this framework proved useful in the beginning to address workforce concerns in a structured way, the Panel realizes that, in reality, extensive overlap exists. Despite this overlap, challenges facing the substance abuse treatment workforce of the future can be well articulated under these core groups.

A. PREVALANT PROBLEMS FOR THE SUBSTANCE ABUSE TREATMENT WORKFORCE

Education and Training

SUBSTANCE ABUSE TREATMENT STAFF. Increased provision of basic education and training standards is widely supported for new substance abuse treatment professionals entering the field. With regard to existing personnel, the field has begun to address the need for standards for basic and continuing education through initiatives such as CSAT's Technical Assistance Publication 21 (TAP 21), *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.*[1] Nevertheless, a number of factors have complicated efforts to develop a standardized approach for staff (i.e., counselors, social workers, and physicians) who require continuing education.

Several issues have constrained the field's ability to formulate and implement a consistent approach to education and training. First, there is no consensus about the best approach to educate and train current substance abuse treatment staff. Second, the political and social environment, particularly dynamic in recent years, continues to transform the context within which this education and training takes place and to modify the nature of the solution. For example, ongoing changes in the substance abuse treatment delivery system have brought about changes in staff competency requirements, largely due to the shift from inpatient to outpatient services under managed care. Third, the lack of specific funding sources designated for education and training activities for new and existing staff further impedes efforts to achieve general agreement.

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[1] Intended to provide guidance for the professional treatment of substance use disorders, Technical Assistance Publication (TAP) Series 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, presents the knowledge, skills, and attitudes required for achieving and practicing the competencies defined in the 1995 publication *Addiction Counseling Competencies.*

Consolidated education and training strategies must be widely applicable to substance abuse treatment personnel from all backgrounds, some of whom may lack formal education and training in addiction. Expansion of the substance abuse treatment system has occurred, in part, because many individuals with personal experience of addiction and recovery have entered the field. This personal experience is often the foundation of their knowledge, work, and commitment.

Some stakeholders are concerned that, unless the substance abuse treatment profession retools its workforce (both staff with and without formal education in addiction), high levels of care and treatment might not be provided universally. In addition, provider reimbursement (from managed care organizations) for substance abuse treatment services may depend on compliance with a prescribed level of education and credentials. Conversely, others feel that if mandatory education and training requirements are imposed, some staff might leave the field because of costs and other barriers associated with gaining the required education. The challenge is to develop an education and training approach for the entire workforce that (a) guarantees that *all* staff can deliver high levels of care and treatment, and (b) meets the needs of a changing client population.

OTHER PROFESSIONALS. All health and human services staff — as well as staff of other agencies — who might be in a position to recognize indicators of substance abuse should receive, at a minimum, training in screening and referral. Although credentialed in their own field, primary care and other professionals might have received little or no education about substance-related disorders. Therefore, professionals in other disciplines who interact with clients with substance-related disorders (e.g., primary care physicians, nurses, psychologists, social workers, psychiatrists, and emergency department staff) also have education and training needs.

Credentialing

Credentialing of addiction treatment staff remains one of the most challenging matters to characterize clearly. Mactas, Trout and Jackson (1996) present three distinct forces that impact the current debate:

- The tradition of practitioners of any art to establish boundaries that communicate who is qualified to practice.
- Pressure exerted by changes in the organization and delivery of healthcare, particularly the move to managed care in the public sector. (Although the field itself struggles with how it will address credentialing internally, the managed care industry dictates from the outside the credentials necessary to receive reimbursement for treating addiction.)

- Recognition that therapists make a difference in treatment outcomes and that those therapists vary in success rate.

Much of the discussion in the Education and Training section also relates to credentialing. The issue is further complicated by the multiple credentialing systems that exist nationally, and the wide variation in credentialing requirements among the States. The Panel advocates for a credentialing process that preserves the value obtained from the diversity of the substance abuse treatment workforce; responds to and supports the objectives and activities of the substance abuse treatment system; and reflects the most current research on effective treatment approaches. The Panel also noted that, in order to be recognized as a profession, a discipline must have a credentialing process that includes nationally recognized educational standards and a national, competency-based examination.

The variety of approaches to individual substance abuse treatment credentialing, both within the counseling profession and in other professions, can be confusing. Most States require that substance abuse treatment professionals be credentialed; it is thought that around two-thirds of the total addiction counselors in the United States are credentialed. The remainder (primarily in the public sector) work under supervision in accredited or approved drug and alcohol treatment programs. However, the prerequisites for credentialing and re-credentialing of substance abuse treatment professionals vary from State to State. Furthermore, other staff in the field, such as registered nurses, social workers, and physicians, are credentialed by their own discipline/professional body and/or by the State. These individuals might also apply for a specialty credential in substance abuse treatment.

Supply, Demand, and Distribution

Maintaining an adequate supply of competent substance abuse treatment staff who are trained to practice at specified levels, from basic entry-level to advanced, and who can address the complex needs of diverse client groups is critical. Yet, the field has not addressed in depth the question of how to ensure the supply and distribution of qualified staff, perhaps because there exist no comprehensive, comparative workforce data for analysis. The possibility of conducting gap analyses is limited because there is no means of reliably identifying numbers and types of staff in the workforce, and which staff are needed where and with what competencies.

In addition to ensuring an adequate supply of credentialed substance abuse treatment counselors with general training, the substance abuse treatment field needs staff to be competent in specific areas. These include co-occurring disorders (such as HIV/AIDS, mental health and disabilities), welfare reform, criminal justice, domestic violence, child protective services, cultural competence, and responsiveness to the diversity of clients with substance use disorders. There is also a demand for all staff to possess an understanding of the function of the substance abuse treatment system, including its inter-relationships with other systems and/or fields, since staff who have program management and administrative skills are also needed. Staff effectiveness partially depends on the structure and management of the program in which they work. Furthermore, staff who work in research or other academic settings and those who can translate research into practice are needed. Although university-based substance abuse treatment education programs offer a variety of education and training curricula, there is a widely held view that economic, social, cultural, and geographic isolation might prevent or deter interested individuals from entering these programs. These and other barriers profoundly affect the supply of competent staff.

B. ANALYSIS

Environmental Context

The Panel notes that the context within which the substance abuse treatment field operates is complex and highly politicized. Particularly in the last fifteen years, the client population and other environmental factors have been notably dynamic and challenging. Recommendations for the workforce developed without an understanding of the field's history, current challenges, and increasing complexity likely will result in a lack of problem resolution, and might even hinder the progress of the substance abuse treatment field. Thus, analysis of this environmental complexity and the major implications for the treatment workforce is critical to developing informed and effective recommendations for the future.

Section IV D, *Factors to Consider in Moving Forward,* presents an analysis of key environmental developments that have affected the substance abuse treatment field in recent years. An issue that impacts the workforce most directly is the ethno-cultural diversity of the treatment population, which is rapidly increasing. This client diversity requires staff to possess and utilize strong, flexible cultural competency skills and sensitivity to the varied needs of these numerous and changing client groups. Furthermore, to ensure that clients receive the best possible care, the workforce must keep current in changes in practice. However, research results are often not readily available or disseminated in accessible forms, which impedes their application in the field.

The Panel believes that developments in health industry structure recently have raised the profile of staff credentialing, education and training, as managed care organizations (MCOs) have linked service reimbursement to workforce requirements in these areas. The gatekeeping strategies of these organizations have reduced dramatically the use of treatment programs, particularly residential treatment, which has led to program cutbacks, closings and, ultimately, job losses in the substance abuse treatment workforce. Social policy legislation, such as Welfare Reform and Drug Free Workplace legislation, has also impacted substance abuse treatment staff. Federal legislation that is not substance abuse-specific also might be important to understand when considering workforce issues. However, inadequate quantitative workforce data hamper policy debates focused specifically on workforce issues. Lack of adequate data also hinders Panel attempts to analyze workforce supply and demand in any meaningful way.

There are no individual funding streams intended specifically for development of the workforce; as a result, funding for workforce initiatives must come from treatment funds. The lack of a specific budget item for the workforce ultimately results in the personal development needs of staff competing with treatment and other patient needs.

Quantitative Analysis of the Substance Abuse Treatment Workforce

Independent substance abuse agencies and/or stakeholder groups have collected data on the workforce. Examples include the Substance Abuse and Mental Health Services Administration's (SAMHSA) ongoing *Office of Applied Studies Alcohol and Drug Service System Study*, the National Association of Alcohol and Drug Abuse Counselors' (NAADAC) *1993 Salary and Compensation Study of Alcohol and Drug Abuse Professionals*, the 1996 selected Addiction Technology Transfer Center (ATTC) *survey of the education level of counselors* (Adams and Gallon, 1997), and the ATTC of New England/Harvard Medical School's *identification of training needs among New England substance abuse treatment providers* (Shaffer, Hall and Vander Bilt, 1995). As a result, there are substantial areas in which the field has gained information on staff groups and specific workforce issues or trends. However, available research data are not linked. Typically, organizations carry out their research studies independently. Consequently, the results do not lend themselves to comparison, and cannot be consolidated to obtain a national picture.

Although before 1994, the National Drug and Alcohol Treatment Unit Survey (NDATUS) collected selected data fields about the staff that make up the national substance abuse treatment workforce, these fields were eventually dropped from the data set (SAMHSA, 1999). The new Uniform Facility Data Set (UFDS), which integrates with the Drug and Alcohol Services Information System (DASIS), contains no information on the substance abuse treatment workforce.

Despite the data collection and research efforts of some agencies, the Panel notes that there is still no current national, common workforce data set or repository of substance abuse treatment staff data. This fact emphasizes the need for new precursory data collection on the workforce, as well as for effective secondary research. Lack of data constrains efforts to analyze and address identified problems in the workforce.

Qualitative Analysis of the Substance Abuse Treatment Workforce

In the absence of adequate quantitative data, Panel analysis has relied on a descriptive, qualitative review of selected current issues that concern substance abuse treatment personnel. This analysis has been distilled primarily from transcripts of Panel speakers and discussions among Panel members during meetings.

The analysis recognizes inherent overlap among the Panel's core issues, Education and Training; Credentialing; and Supply, Demand, and Distribution, and illustrates the depth, breadth, and complexity of the challenges foremost in the minds of Panel members. During the process, Panel members generated many potential solutions and recommendations, suggesting numerous ideas for developing and preparing the workforce for the future. Their discussion is summarized below.

Education and Training

INTERNAL ISSUES. The particular skill set that each member of the workforce requires to work competently and effectively depends on his or her discipline or employing agency, treatment modalities within which the individual works, staff practice level, and the client population served. Staff working with different client groups, in different specialty areas, or in various allied fields have diverse needs for substance abuse treatment education and training. For example, staff working in residential settings encounter different education, training, knowledge, and skill requirements than those working in private practice or in community mental health clinics. Further, the substance abuse treatment knowledge and skills of primary care practitioners are critical because the primary care system is a principle vehicle for accessing the substance abuse treatment system. However, the competency of these practitioners in addressing addiction is inconsistent. Primary care staff might not understand addictive disease, often lack the ability to screen a client, and might not be prepared to intervene or to refer. This training gap also occurs among other health and human services and criminal justice staff.

CSAT's TAP 21, *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*, identifies the competencies the Panel considers important to the substance abuse treatment system; these competencies should be incorporated into the core curriculum of addiction education and training programs. TAP 21 is divided into two sections. The first identifies the knowledge and attitudes that underlie competent practice for counselors and addiction specialists in other disciplines. Functional skills might vary across disciplines, but the knowledge and attitudes highlighted here provide a basis of understanding that should be common to all addiction professionals and that serve as a prerequisite to development of competency in each discipline. These foundations are Understanding Addiction; Treatment Knowledge; Application to Practice; and Professional Readiness. The second section addresses the professional practice of addiction counseling. Eight practice dimensions are identified, with counselor effectiveness depending on the individual's ability to develop expertise in each. These dimensions include Clinical Evaluation; Treatment Planning; Referral; Service Coordination; Counseling; Client, Family, and Community Education, Documentation; and Professional and Ethical Responsibilities.

In addition to standards for basic education and training, national standards for continuing education are needed. Such standards will sustain the ongoing delivery of appropriate and effective services by qualified individuals possessing knowledge of recent developments in practice. Continuing education standards might also guard against the use of less expensive practitioners whose knowledge is not up to date. One positive development requires that continuing education for all substance abuse and mental health treatment staff be written into substance abuse treatment contracts between providers and government agencies or other payors. Moreover, several states have enacted legislation that requires continuing education for re-credentialing addiction counselors. Despite these examples of good practice in continuing education, such approaches are far from universal.

Based on the hypothesis that all practitioners do not require the same level of skills and expertise and that the field should develop differentiated scopes of practice, a model of clinical hierarchy is needed. In such a hierarchy, substance abuse treatment personnel can progressively move along a continuum of increasing levels of knowledge, competency, and application during their career. Different continuing education requirements, clinical and technical competency, and supervision skills are associated with each level. Such a career ladder provides a protocol for basic and continuing education and training, encourages development of supervisory and program management skills, and, potentially, would improve staff retention by providing a clear career path for the workforce.

Notwithstanding the tremendous variation among State credentialing and re-credentialing requirements, which has been a barrier to the development of national education and training standards, it is imperative to avoid a "one size fits all" approach to consolidating the existing fragmented education and training system. Any single solution is unlikely to address the complexity of client needs. Although many academic programs focus exclusively on didactic education, effective education and training programs require a combination of didactic training and supervised clinical experience. Finally, many health and human services professionals frequently are unaware of the need to learn about addictive disorders.

Current resources for education and training programs are not uniformly accessible or available. In rural or otherwise isolated communities, there is a particular shortage of education and training opportunities. This problem is particularly prevalent among Native American and other remote populations. Few local colleges in under-resourced ethnic communities offer education programs in substance abuse treatment. Distance from academic institutions that offer specialized addiction education is often a deterrent. Further, too few fellowships, stipends, and loan-forgiveness programs are offered to assist under-resourced individuals.

The Panel notes that lack of access and availability is exacerbated by the context of the financial constraints characteristic of this field. Because salaries and wages, particularly for addiction counselors, are not competitive with those of other professions, staff often cannot afford to repay college loans when they enter the workforce. Nor can they afford to invest in continuing education, such as graduate programs. Furthermore, the reimbursement system third-party payors use does not reimburse providers for staff education and training activities, and there has been a decrease in education and training funds available through Federal grants. As a result, funding is needed to support the availability and accessibility of pre-service and continuing education. Still, the Panel recognizes the importance of the personal responsibility incumbent on each individual in the substance abuse workforce to keep current with changing technologies and treatment approaches.

Such limited access to and availability of education and training results in an inadequate supply of appropriately trained, qualified, and/or credentialed substance abuse treatment staff reflective of the client population. There is also an indirect impact on program revenue, such that treatment programs lacking staff with grant writing, evaluation, and other research skills might prove unable to access funds. Although this occurs throughout the country, it is particularly prevalent in Native American and other rural, remote, and culturally distinct communities (e.g., Hispanic, African American). Here, the lack of access to education and training severely limits availability of qualified staff and treatment programs in the very communities that suffer from the highest incidence of addiction.

EXTERNAL ISSUES. The risk for substance abuse treatment programs of losing reimbursement from third-party payors is a significant motivator to increase the availability and quality of addiction education and training. Third-party payors may discontinue reimbursement if programs do not comply with minimum educational requirements for staff. Private payors and other funding agencies have variable education and training requirements. Although these requirements might be similar at the level of basic training, advanced training requirements are different from payor to payor. For the student, the demands of academic institutions further complicate this situation. Individual academic programs set entry requirements for substance abuse-specific degrees, which often results in considerable diversity in the requirements students must fulfill.

Various external education and training requirements have raised concerns for those staff who do not have formal education or training in addiction. Mandatory education and credentialing may be perceived as an insurmountable obstacle by some staff who are unable or unwilling to undertake a formal addiction education program because of the cost or other factors.

Credentialing

INTERNAL ISSUES. The absence of consistent, national, mandated standards and processes for the credentialing of addiction counselors has resulted in substantial variation in credentialing approaches from State to State. A variety of approaches and criteria makes for considerable inconsistency, might limit the application of best practices in some States due to restrictive rules, and, despite reciprocity arrangements for counselors, can make it difficult for counselors to practice in other regions. Because there are also no national standards for education, no clear link exists between systems for credentialing and those for education and training, which can result in some curricula not appropriately preparing students for credentialing exams. Creating particular problems is the lack of nationwide standards to determine which counselors can treat clients.

The lack of progress toward development of a unified, national process for credentialing addiction counselors might stem, in part, from the variety of possible approaches and the variety of interests that exist. The role of staff in the workforce who have no formal education, or no formal education in addiction, presents a particular challenge in the field's efforts to define and require professional qualifications and standards. A general lack of accessibility to education in addiction for counselors and others exacerbates this situation. Practitioners in some disciplines, credentialed in their own field, can obtain a specialty credential in addiction (i.e., registered nurses, psychologists, psychiatrists, social workers [master's degreed]). If a specialty credential in addiction is unavailable for a particular discipline, those professionals can obtain a credential as an addiction counselor.

EXTERNAL ISSUES. A major force behind the move toward credentialing substance abuse treatment staff (and/or accrediting or otherwise approving treatment programs) is the managed care industry, whose insurers and third-party payors often dictate the credentialing requirements for substance abuse treatment programs and staff. Among those MCOs that include substance abuse treatment as a reimbursable benefit, there are many different approaches to ensuring standards. To qualify for reimbursement with some MCOs, substance abuse treatment personnel need specialized education and training, including degrees in rehabilitation counseling, psychology, social work, and addiction studies. Other MCOs have different requirements. Despite the obvious benefits of this emphasis on credentials, the driving force should be the field itself, not outside bodies such as MCOs. This is especially pertinent because these organizations are unlikely to remain as they are now but, rather, will themselves change in the future. It is important for the field to regain the initiative and develop its own solutions and systems to demonstrate standards and competency. Additionally, non-accredited programs may be delivering interventions that do not have proven outcomes. Without a nationwide system of minimum credentialing standards, the field cannot intervene when the effectiveness of such programs is in question.

Supply, Demand, and Distribution

INTERNAL ISSUES. Over the last several decades, many individuals entering the field with a personal history of addiction and recovery have facilitated, in part, the expansion of the substance abuse treatment system. Regardless of this growth and other workforce expansion, supply and demand constantly fluctuate. Currently, some employers suffer a lack of qualified staff, while other experienced mid-level staff are losing their jobs.

Availability of human resources is generally accepted to be a product of economic, political, geographic, social, and technical factors. This is true for the substance abuse treatment field, specifically in rural, isolated regions in which there are inadequate numbers of staff possessing certain skills, mainly cultural competency. To be successful, treatment modalities must be based on traditions, language, customs, and values. However, Native Americans, Hispanics, African Americans, Asians, and recent immigrants often find that culturally sensitive treatment is unavailable, even in areas with high concentrations of these population groups. This staffing shortfall is widely linked to lack of investment in addiction education, lack of access to alternative education sources such as distance learning, lack of appeal of a career in substance abuse treatment, and low salaries.

Indeed, limited revenue within substance abuse treatment programs represents a major factor affecting the supply of and demand for qualified staff, particularly in those areas that are identified as disproportionately affected by chemical dependency. These funding limitations include low salaries, which discourage people from entering or staying in the field, and restricted recruitment and staffing opportunities for program managers, whose agendas are frequently driven by funding availability as much as by clinical need. Often program administrators must choose between staff development and program development when deciding how to spend treatment dollars. Similar issues contribute to staff losing their jobs where employers, seeking to cut costs and stretch finite revenues, employ underqualified, non-credentialed, or inexperienced staff instead of more expensive, qualified staff. Such daily management decisions affect the supply of and demand for staff nationwide. Consequently, in some areas, the employment security of qualified addiction counselors might be threatened by multiple calls on limited revenue.

There are anecdotal reports of private providers and, in some instances, county provider systems, offering consistently higher salaries and more attractive benefits than independent or nonprofit providers. In this environment, qualified personnel in public or not-for-profit providers routinely leave to work for higher paying providers, particularly under circumstances in which they have not received a pay raise for several years. The Panel believes that this threatens the supply and retention of credentialed staff in certain sectors, which affects the ability of programs to meet client need. Lack of salary parity with other healthcare professionals, who typically enjoy a higher income, exacerbates these circumstances, particularly in the public sector.

It is anticipated that, in the future, more treatment staff will be required for key racial and ethnic groups such as Native Americans, Puerto Ricans, African Americans, and Mexican Americans. More treatment staff will also be needed for most age groups, including the children of substance abusing parents, adolescents, and the elderly. Furthermore, staff trained in addiction counseling will be needed in primary care, public health, and settings such as schools and colleges. Currently, how this staff expansion will be achieved remains unclear. Within the academic field, it is also unclear how the increasing numbers of retiring faculty will be replaced to train the workforce of the future.

Other Workforce Related Issues

INTERNAL ISSUES. The substance abuse treatment field lacks consistent, prescribed national treatment standards such as clinical practice guidelines, procedures, and protocols. Moreover, practice guidelines that do exist might not reflect developments in knowledge, practice, and technology that have taken place in recent years. In the past, staff worked well within this open environment; however, with the increasing complexity of the client population, guidelines are becoming more necessary. Although seemingly a treatment system issue rather than a workforce issue, lack of formalized practice guidelines results in potential for treatment system staff to implement inconsistent approaches, use unproven treatment modalities, and work toward different treatment outcomes.

Of even greater concern is the impact on staff of other agencies that come into contact with substance abuse treatment clients (e.g., social services, criminal justice) because there are no requirements for them to meet minimum practice standards or standards of clinical competence. National, formalized, mandatory practice guidelines, including minimum standards, are needed to provide models of best practice and staff competency that are trans-disciplinary (i.e., working across professional boundaries) and interdisciplinary. Such guidelines and standards will also focus the substance abuse treatment workforce and other allied staff on optimizing clinical outcomes, underpin the development of core curricula for staff education and training programs, and contribute to the development of credentialing processes.

Panel members acknowledge that research results are not readily available in language and formats that are accessible, comprehensible, or relevant to all treatment staff. During public hearings, testimony indicated that some clinicians on the front line do not consistently understand the latest research findings on new treatment practices or how the research was conducted. Treatment personnel are not widely involved in research activities, and research results are not disseminated in a way that allows the workforce to develop or refine treatment practice in the field.

Some see the extent to which substance abuse treatment personnel interact with each other and with staff of other health and human services-related services as an emerging issue of importance. Due to its bifurcated nature, using a range of specialized professionals (e.g., child welfare, HIV/AIDS, and other subspecialties) is a fragmented approach to treating substance-related disorders. Tension exists between providing substance abuse treatment through a variety of different specialists and the alternative notion of taking a whole person approach. The field has yet to determine how to develop and implement a treatment approach combining the best characteristics of staff integration and staff specialization into an integrated model.

EXTERNAL ISSUES. The Panel believes that the lack of funding for substance abuse treatment in the healthcare system interferes with the ability of treatment programs to maintain the required quality of staff experience levels, qualifications, education and training.

The concept of viewing the client as a whole and meeting his or her needs holistically involves a great deal of trans-disciplinary work with other health and human service providers to provide seamless services. However, the Panel feels that clinical integration should not be taken to such extremes that system integration leads to the substance abuse treatment workforce's being subsumed by another service.

III. Recommendations

In light of the qualitative analysis, the question emerges: "Given these trends, how can the substance abuse treatment system establish and maintain sufficient numbers and quality in the workforce?" In seeking an answer, the Panel has produced a composite of the ideal workforce of the future, generating forward-looking statements that describe their vision for the treatment system and the workforce.

VISION STATEMENT

The Substance Abuse Treatment System

ACCESS. Substance abuse treatment system services will be readily accessible to the community at large through multiple geographically convenient entry points. The treatment system will provide timely, affordable, and comprehensive treatment on request and will be fully funded through a variety of public and private sources and reimbursement mechanisms.

TREATMENT ENVIRONMENT. The treatment system will be seamless (see Glossary) and will include multiple evidence-based treatment modalities and options. It will provide a safe, flexible, and accountable environment.

RANGE OF TREATMENT. The treatment system will provide integrated, comprehensive treatment through a spectrum of qualified professionals. Treatment will benefit from state-of-the-art clinical and information technology.

RESPONSIVENESS. Serving the unique needs of each client, the treatment system will provide client-focused care that responds to the needs of different population groups. It will be respectful and empowering to the individual and free from stigma. The system will acknowledge and adapt to the condition of each client's individual social support and community-based support systems.

The Substance Abuse Treatment Workforce

CLINICAL PRACTICE. The substance abuse treatment workforce will use evidence-based practices that are value- and outcome-driven.

STAFF RELATIONSHIPS. The treatment workforce will be team-oriented and interdisciplinary.

STAFF CLIENT RELATIONSHIPS. The treatment workforce will better reflect the variety of client populations and demonstrate cultural sensitivity and competency.

STAFF SUPPORT INFRASTRUCTURE. The treatment workforce will be grounded in education, training, clinical supervision, and credentialing processes that are defined by the complexity of evolving client needs and treatment research. Additionally, the workforce will establish processes for advancement, including career ladders, appropriate compensation, and increased responsibility based on competency.

GOALS AND RECOMMENDATIONS

Visualizing the desired future has made it easier for the Panel to identify the most important issues and the activities required to address them. To drive the development of workforce recommendations the Panel formulated three goals (see Figure 1, shown earlier) as follows:

- Provide a national platform to address workforce issues.
- Develop and strengthen a comprehensive infrastructure that attracts, supports, and maintains a competent, diverse workforce, reflective of its client populations.
- Improve the competency of a diverse addiction workforce by providing didactic, clinical, and experiential education and training based on a core body of the latest evidence-based knowledge.

GOAL 1: PROVIDE A NATIONAL PLATFORM TO ADDRESS WORKFORCE ISSUES.

Recommendation 1.1: Establish a National Workforce Development Office at CSAT.

There exists a need for a Federal agency specifically dedicated to supporting the development of the substance abuse treatment workforce at a national level. Of the previous recommendations on workforce issues, none have addressed this requirement. A need exists, as well, for a nationwide source of valid, comparable data on the workforce and use of that data to guide legislative and policy decisions regarding the workforce. Furthermore, it is important that addiction education and training be based on addiction research findings.

CSAT will immediately establish a National Workforce Development Office, which will collaborate with the Indian Health Service (IHS), the Health Research Services Administration (HRSA), the Office of Minority Health, and other Federal agencies to implement the action steps.

Action Steps

The National Workforce Development Office should perform the following tasks:

- Develop a comprehensive report on the state of the workforce. (The National Workforce Development Office will employ data from a comprehensive national report on the state of knowledge in the addiction field and will be instrumental in encouraging or supporting individuals and/or bodies to undertake this research.)
- Provide leadership in the collection, use, and application of comparative nationwide workforce data for decision-making at Federal, State, and local policy levels.
- Develop and monitor cross-disciplinary competency guidelines.
- Facilitate a multi-disciplinary process to develop a core curriculum (based on CSAT's TAP 21), which will form the basis for credentialing standards.
- Monitor the inclusion of basic addiction-related curricula in education and training programs.
- Monitor and facilitate the implementation of CSAT NTP Workforce Issues Panel recommendations.

GOAL 2: DEVELOP AND STRENGTHEN A COMPREHENSIVE INFRASTRUCTURE THAT ATTRACTS, SUPPORTS, AND MAINTAINS A COMPETENT, DIVERSE WORKFORCE, REFLECTIVE OF ITS CLIENT POPULATIONS.

Recommendation 2.1: Establish funding mechanisms to support workforce recruitment, retention, and development initiatives.

The absence of adequate funding and other strategies to recruit, educate, and retain a diverse workforce has meant a lack of staff with sufficient linguistic skills and cultural competence to meet the diverse needs of all client populations represented in the substance abuse treatment system. Previous workforce-specific recommendations are applicable to this recommendation but lack specificity and focus.

Financial incentives might involve establishing loan forgiveness, scholarship, and stipend programs, particularly for individuals from targeted under-represented population groups. CSAT should work with relevant agencies (e.g., SAMHSA, HRSA, the National Institute on Drug Abuse [NIDA], the National Institute on Alcohol Abuse and Alcoholism [NIAAA] and the National Institute of Mental Health [NIMH]), to identify and coordinate adequate funding opportunities to support workforce development.

Action Steps

- Advocate for salary parity.
- Develop strategies and financial incentives to meet workforce supply shortfalls.
- Develop strategies and financial incentives to attract staff reflective of the treatment population.
- Identify and use innovative funding sources to expand training opportunities (particularly for under-resourced population centers).
- Secure funding for a Workforce Development Mentoring Initiative.

Recommendation 2.2: Advocate for competency-based career ladder opportunities in addiction treatment settings.

Lack of professional and/or career opportunities for advancement in the addiction field and/or treatment setting equates to an absence of a competency-based career path in the substance abuse treatment system. There is a requirement for adequate support for staff attainment of basic through advanced competencies. Previous workforce-specific recommendations have not addressed the need for a career ladder.

The Workforce Development Office, created by CSAT, should take responsibility for developing the competency-based career path for the substance abuse treatment system. Individual programs might need to adapt the career ladder relevant to their treatment setting. Furthermore, staff have the professional responsibility to pursue their own advancement by keeping up to date and seeking opportunities for continuing education and training. Financial and other incentives may be secured for workforce development at Federal, State, and local levels.

Action Steps

- Develop a competency-based career path in the substance abuse treatment system.
- Create and support opportunities for competency-based professional advancement.

***Recommendation 2.3:* Advocate for all health and human service-related accrediting and certifying/re-certifying agencies to require education and competence in addiction, and inclusion of addiction questions on all credentialing exams.**

There is a requirement for all healthcare professionals to possess basic competence — knowledge, skills, and attitudes — for meeting the needs of clients with substance use disorders. Basic addiction knowledge, skills, and attitudes among the workforce must be common to all disciplines.

CSAT will convene a working group consisting of States, the National Association of State Alcohol and Drug Abuse Directors (NASADAD), credentialing bodies, professional organizations, and treatment provider associations to implement this recommendation.

Action Steps

- Develop and disseminate model competency-based State credentialing standards for addiction counselors as well as other health and human services disciplines.
- Collaborate with State and professional credentialing bodies, academic institutions, and treatment providers.

***Recommendation 2.4:* Establish standards for didactic, clinical, and experiential education and training of addiction professionals and other health and human services providers.**

Uneven quality of substance abuse treatment, a direct result of a number of variable standards for education and training of addiction professionals, indicates a need for research on the most effective methods for educating and training addiction professionals and other health and human services providers, and a requirement to establish minimum standards for basic and continuing education in addiction. Moreover, the need extends to national consistency among curricula, education, and training approaches and access to education and training. Further evidence of the importance of instituting national standards resides in the varying emphasis placed on client-centered care and practica. Previous workforce-specific recommendations are applicable to this recommendation but lack specificity and focus.

CSAT should work with relevant Federal agencies, professional organizations, academic institutions, and treatment providers. This work might involve the development of a think tank on academic/ treatment program partnerships and encouragement of collaboration between academic institutions and providers.

Action Steps

- Conduct research to determine the most effective methods for educating and training addiction professionals.
- Provide a clearinghouse for education and training information as well as trainers for onsite training.

Recommendation 2.5: Advocate for and encourage academic institutions to develop and offer degree programs for addiction professionals at the undergraduate and graduate levels.

There exists a need to enhance and encourage formal academic education for the addiction workforce. CSAT will encourage and support the establishment of additional degree programs by providing appropriate incentives such as faculty or curriculum development grants and contracts.

Action Steps

- Expand the number of available academic degree programs in addiction.
- Increase accessibility to these programs using distance learning and non-traditional strategies.

GOAL 3: IMPROVE THE COMPETENCY OF A DIVERSE ADDICTION WORKFORCE BY PROVIDING DIDACTIC, CLINICAL, AND EXPERIENTIAL EDUCATION AND TRAINING BASED ON A CORE BODY OF THE LATEST EVIDENCE-BASED KNOWLEDGE.

Recommendation 3.1: Ensure the development of core curricula based on CSAT's Technical Assistance Publication 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice, for the education of addiction counselors.

There exists a need for comprehensive evidence-based curricula for addiction counselors. Previous workforce-specific recommendations are applicable to this recommendation but lack specificity and focus.

CSAT should work with HRSA, academic institutions, professional organizations, ATTCs, and education and training program networks to review existing curricula and establish a clearinghouse. Core curricula can be produced within two years, with dissemination and promotion ongoing over a 10-year period.

Action Steps

- Review existing addiction curricula to identify gaps.
- Develop undergraduate and graduate curricula based on: (1) the existing needs and gaps; and (2) substance abuse treatment field-endorsed competencies for basic, advanced, and discipline-specific curricula.
- Develop, update, and disseminate research-based curricula appropriate for addiction counselors (based on CSAT's TAP 21).
- Ensure all addiction treatment curricula and materials emphasize client-centered, respectful, and client-empowering assessment and treatment.
- Require addiction-specific clinical rotations or practice-based learning in all education and training programs for addiction counselors.

Recommendation 3.2: Ensure inclusion of basic addiction-related curricula in all levels of education and training programs for health and human services providers, that is appropriate for their scope of practice.

Previous workforce-specific recommendations are applicable to this recommendation but lack specificity and focus. At the same time, there is a requirement for all healthcare professionals to possess basic competence — knowledge, skills, and attitudes — for meeting the needs of clients with substance use disorders. It is essential that basic addiction knowledge, skills, and attitudes among the workforce be common to all disciplines. Therefore, to improve the competency of a diverse addiction workforce, substance abuse treatment and addiction curricula must be included at the undergraduate, graduate, and post-graduate/continuing education levels, and client-centered care in addiction-related education and training curricula must be emphasized.

CSAT should work with HRSA, academic institutions, professional organizations, ATTCs, and education and training program networks to review existing curricula and establish a clearinghouse. Core curricula can be produced within two years, with dissemination and promotion ongoing over a 10-year period.

Action Steps

- Review existing general and discipline-specific addiction curricula to identify gaps.
- Develop core interdisciplinary undergraduate and graduate curricula based on: (1) the existing needs and gaps; and (2) substance abuse treatment field-endorsed competencies for basic, advanced, and discipline-specific curricula.
- Develop, update, and disseminate research-based curricula appropriate for various disciplines (based on CSAT's TAP 21).
- Ensure all addiction treatment curricula and materials emphasize client-centered, respectful, and client-empowering assessment and treatment.
- Require addiction-specific clinical rotations or practice-based learning in all education and training programs.

Figures 2, 3, and 4, which follow, illustrate The Goals, Recommendations, and Action Steps discussed.

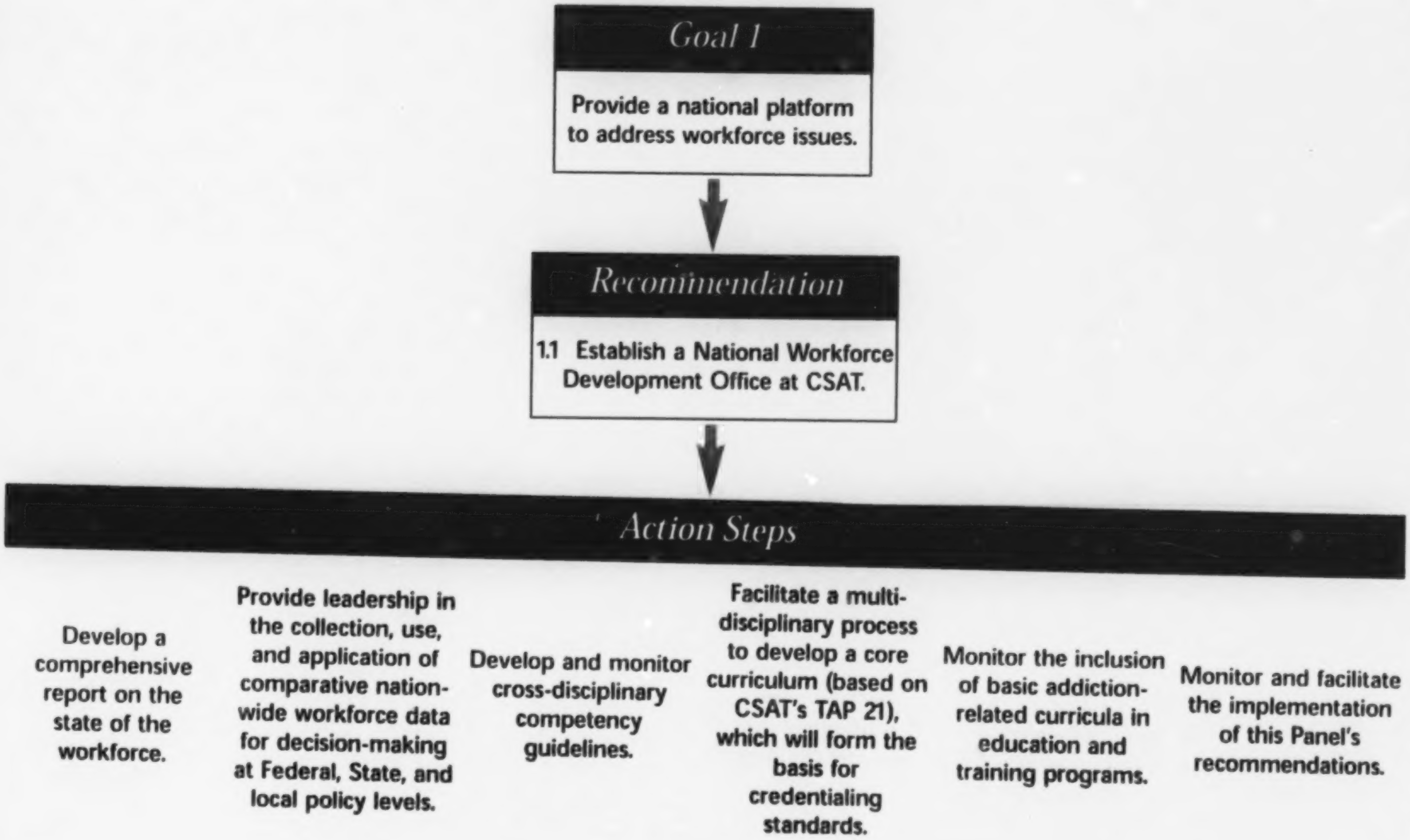

Figure 2. Goal 1, Recommendation and Action Steps

Goal 1

Provide a national platform to address workforce issues.

Recommendation

1.1 Establish a National Workforce Development Office at CSAT.

Action Steps

- Develop a comprehensive report on the state of the workforce.
- Provide leadership in the collection, use, and application of comparative nationwide workforce data for decision-making at Federal, State, and local policy levels.
- Develop and monitor cross-disciplinary competency guidelines.
- Facilitate a multidisciplinary process to develop a core curriculum (based on CSAT's TAP 21), which will form the basis for credentialing standards.
- Monitor the inclusion of basic addiction-related curricula in education and training programs.
- Monitor and facilitate the implementation of this Panel's recommendations.

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Figure 3. Goal 2, Recommendations and Action Steps

Goal 2

Develop and strengthen a comprehensive infrastructure that attracts, supports, and maintains a competent, diverse workforce, reflective of its client populations.

Recommendations	2.1 Establish funding mechanisms to support workforce recruitment, retention, and development initiatives.	2.2 Advocate for competency-based career ladder opportunities in addiction treatment settings.	2.3 Advocate for all health and human services-related accrediting and certifying/re-certifying agencies to require education and competence in addiction, and inclusion of addiction questions on all credentialing exams.	2.4 Establish standards for didactic, clinical, and experiential education and training of addiction professionals and other health and human services providers.	2.5 Advocate for and encourage academic institutions to develop and offer degree programs for addiction professionals at the undergraduate and graduate levels.
Action Steps	Advocate for salary parity. Develop strategies and financial incentives to meet workforce supply shortfalls. Identify and use innovative funding sources to expand training opportunities (particularly for under-resourced population centers). Secure funding for a Workforce Development Mentoring Initiative.	Develop a competency-based career path in the substance abuse treatment system. Create and support opportunities for competency-based professional advancement.	Develop and disseminate model competency-based State credentialing standards for addiction counselors as well as other health and human services disciplines. Collaborate with State and professional credentialing bodies, academic institutions, and treatment providers.	Conduct research to determine the most effective methods for educating and training addiction professionals. Provide a clearinghouse for education and training information as well as trainers for on-site training.	Expand the number of available academic degree programs in addiction. Increase accessibility to these programs using distance learning and non-traditional strategies.

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Figure 4. Goal 3, Recommendations and Action Steps

Goal 3

Improve the competency of a diverse addiction workforce by providing didactic, clinical, and experiential education and training based on a core body of the latest evidence-based knowledge.

Recommendations

3.1 Ensure the development of core curricula based on CSAT's TAP 21 for the education of addiction counselors.

3.2 Ensure inclusion of basic addiction-related curricula in all levels of education and training programs for health and human service providers, that is appropriate for their scope of practice.

Action Steps

Review existing addiction curricula to identify gaps.

Develop undergraduate and graduate curricula based on: (1) the existing needs and gaps; and (2) substance abuse treatment field endorsed competencies for basic, advanced, and discipline-specific curricula.

Develop, update, and disseminate research-based curricula appropriate for addiction counselors (based on CSAT's TAP 21).

Review existing general and discipline-specific addiction curricula to identify gaps.

Develop core, interdisciplinary undergraduate and graduate curricula based on: (1) the existing needs and gaps; and (2) substance abuse treatment field-endorsed competencies for basic, advanced, and discipline-specific curricula.

Develop, update, and disseminate research-based curricula appropriate for various disciplines (based on CSAT's TAP 21).

Ensure all addiction treatment curricula and materials emphasize client-centered, respectful, and client-empowering assessment and treatment.

Require addiction-specific clinical rotations or practice-based learning in all education and training programs for addiction counselors.

Require addiction-specific clinical rotations or practice-based learning in all education and training programs.

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IV. Discussions: Opportunities for the Future

A. EDUCATION AND TRAINING

Panel members have identified a number of actions integral to developing an approach that will improve the substance abuse treatment education and training system. Of primary concern is the fundamental restructuring of the education and training system to direct and support the development of a core body of evidence-based knowledge. As part of this approach, panelists support supervised clinical experience in all education programs. Scientific research comparing client outcomes from different modalities would also prove useful in helping practitioners to determine standardized treatment practices.

It is important to recognize that availability of and accessibility to this education and training remain challenges for some. Strong incentives, loan forgiveness, fellowships, grants, and other forms of financial support for pre-service and staff education would render education and training more accessible, particularly in rural and other isolated and under-resourced areas. Provision of financial incentives or other rewards and recognition can further encourage staff to undertake advanced training or continuing education. More innovative and flexible approaches to educating staff with available funding streams (e.g., State and Block Grant funds) represent additional ways to engage interest and create opportunities for self-improvement among addiction personnel. In addition, new technology will increase access to education and training for economically, socially, and geographically isolated communities through distance learning and by establishing new academic centers in needy areas.

Culturally appropriate education and training programs that address the varying levels of educational backgrounds of students and staff are necessary given that substance abuse treatment personnel come from diverse backgrounds, and many personnel lack formal education and training and/or some personal experience with addiction and recovery. Core substance abuse treatment education appropriate to their scope of practice should be routine for all health and human services practitioners who come into contact with substance abusing clients. Addiction education and training for staff in other healthcare fields should be flexible and should not require more high-level study or large time commitments.

B. CREDENTIALING

Conceiving and instituting uniform standards for the substance abuse credentialing system has emerged as a principle concern for Panel members, who have identified a series of measures for pursuing that end. An initial action should be to convene a forum of divergent credentialing groups possessing different requirements, with the objective of jointly creating unified, or at least more similar, approaches to credentialing nationwide. This forum can collaborate on developing and implementing quality assurance mechanisms, using agreed-upon minimum standards (e.g., TAP 21). At the same time, the field should support and promote innovative models and approaches to credentialing that are flexible and able to grow and change with the needs of the clients and the workforce.

A credentialing system for substance abuse treatment counselors that is national will offer staff the advantage of more geographic flexibility in where they work, sometimes a deciding factor when planning a career and looking for employment. For this reason, such added advantages can make a difference for recruitment efforts. With further respect to recruiting, an outcomes-based approach to solving credentialing issues, which is based on defining the knowledge, skills, and attitudes necessary for obtaining required/expected client outcomes, is desirable. Administrators should identify and recruit individuals that have these competencies.

The field must consider public protection through mandating a consistent approach to credentialing and accountability across the whole field. To address accountability, a consistent, mandatory credentialing system, which includes penalties for non-credentialed staff demonstrating unethical or poor practice, is essential for all staff groups.

The field also needs to address issues of "professional scope of practice" by embedding national standards in the recommendations for credentialing systems in order to reinforce substance abuse treatment workers as valued professionals. Creating a "credentialed substance abuse treatment professional" in all States, who enjoys parity with other credentialed professionals, can only serve to increase visibility of and foster respect for addiction personnel and the work they do.

Substance abuse treatment personnel should work toward developing a field-wide, shared understanding and expectation of recovering staff. Treatment personnel will need to clarify the degree of personal recovery expected from a member of staff in recovery, and to define the extent of progress he or she must have made in dealing with his or her own issues and in taking on a "clean and sober" lifestyle.

Finally, the Panel feels that payors should reimburse credentialed substance abuse treatment counselors on equal terms with other credentialed professionals, and that the field must work toward procuring fair treatment for its qualified members.

C. SUPPLY, DEMAND, AND DISTRIBUTION

Ensuring an adequate supply of staff is of utmost importance to improving both the availability and the quality of substance abuse treatment. Panel members believe that the number of individuals employed in the substance abuse treatment field will meet demand if the field takes steps to make most effective use of existing staff and to attract new, qualified personnel. One way this can be achieved is by developing creative approaches to make more substance abuse treatment personnel available to community-based primary care clinics, despite the lack of funding for such staff. Also, practitioners must propose solutions and recommendations for workforce issues that promote, reinforce, and build on the concept of the interdisciplinary healthcare team. In particular, physicians should be working closely and flexibly with substance abuse treatment staff as an integral part of the client treatment team. Redistribution of available human and program resources to focus on areas with insufficient staff to meet the increasing demand of disadvantaged populations (e.g., Native Americans, Puerto Ricans, African Americans and Mexican Americans) will also help deliver care where it is most needed and currently least provided. Finally, implementation of strategies to develop and maintain addiction faculty positions in academic institutions will lend credibility to and increase respect for this burgeoning area of healthcare, thereby encouraging a flow of competent individuals to the field.

D. FACTORS TO CONSIDER IN MOVING FORWARD

Client Population

The profile of the national population continues to change as a consequence of demographic and social developments such as rising immigration, the prevalence of single-parent or other "non-traditional" family groupings, and growing numbers of elderly people. These national demographic changes, as well as political developments and economic trends, contribute to the changing demographic profile of the substance abusing population.

The Panel has determined that, in recent years, numbers of clients who are sent for treatment as a result of welfare reform, criminal justice sentencing, or legislation on the drug-free workplace have increased. Also evident is an increase in the ethno-cultural diversity of client populations and, particularly in the African American and Puerto Rican communities, an increase in numbers of substance abusing mothers. In addition, more clients with co-occurring substance-related, cognitive, physical, and developmental disorders are seen, as are more clients who abuse multiple substances.

The Panel feels that there is an increasing awareness of the negative impact of the social environment in which some individuals with or at-risk for addiction might find themselves. However, panelists have noted that staff are also seeing increasing numbers of individuals with substance use disorders who are able to hold stable jobs in the national workforce. (This includes the developing role of clients and former clients in the substance abuse treatment workforce.) The substance abuse treatment workforce is becoming increasingly aware of and sensitive to emerging population groups in the addicted population, including the elderly, the disabled, the bi- and transsexual populations, and those using emerging drugs.

The impact of these changes on the substance abuse treatment system is seen in recent changes in practice that impact the substance abuse treatment workforce. For example, the increasing prominence of outreach workers is attributed to the need to address the increasing occurrence of addiction within ethnic groups, and to bring these clients into the treatment system. Furthermore, the increasing ethno-cultural diversity in the treatment population calls for a more ethnically and culturally diverse workforce or, at least, a workforce comprising staff familiar with and sensitive to the cultural issues of the numerous, changing client groups. To achieve good treatment outcomes, staff will have to work flexibly, adapt their approach to the needs of the individual client, and become competent in addressing the needs and issues of the client's emotional support network.

Health Industry Structure and Impact of Managed Care

MCOs emerged through a desire to control increasing health expenditures in the United States. Therefore, their primary concerns are to ensure that providers are not providing "too much" or "unnecessary" care and that services provided are competitively priced. The MCO system has used several approaches to achieve these objectives, including external gatekeepers, restricted provider networks, credentialing requirements, utilization and performance management, and quality of care indicators. Some panelists believe that these managed care mechanisms have been particularly difficult to adopt in the substance abuse treatment field. The arrival of managed care in the treatment system raised a variety of issues affecting the substance abuse treatment workforce. Some key issues include the requirement for demonstrated competence, the link between credentialing and reimbursement and the resultant implications for non-credentialed staff in the workforce, the expansion of outpatient treatment programs and the resulting restructuring, and the tension between financial and clinical interests.

First, to secure reimbursement for their services from private health companies, the majority of providers in the substance abuse treatment field have been required to implement significant organizational and structural change. The impact of credentialing requirements on staff and providers has also been significant in recent years. To become legitimate providers within an MCO network, substance abuse treatment providers had to secure and demonstrate program and/or individual credentialing standards. A fairly wide range of "standards," including the Joint Commission on Accreditation of Health Care Organizations (JCAHO), Medicaid, and State credentialing standards, affected provider agencies as well as their workforce. However, many socially and geographically isolated and/or other under-resourced communities have not had the capacity to address these requirements, which has constrained substance abuse treatment providers in these communities from generating revenue from MCO payor sources. Some Panel members were concerned that the requirements of MCOs might have had a particularly marked impact in rural, remote, and culturally distinct communities that lack the resources necessary to develop the stable network of services required by private payors. Their limited infrastructure has prevented them from building MCO service capability or addressing the credentialing requirements of these payors.

Second, MCO use of active gatekeeping strategies dramatically reduced the use of inpatient and residential treatment programs, and many counselors lost jobs during periods of hospital-based and other residential program cutbacks and closings. The reduction in reimbursement and subsequent downsizing led treatment agencies to amalgamate to ensure survival. In inpatient settings, substance abuse treatment programs were often subsumed within mental health/psychiatry departments. On the outpatient side, small providers merged or were acquired by larger agencies.

Finally, joint initiatives between substance abuse treatment providers and other agencies (e.g., Criminal/Juvenile Justice, Child Welfare, and Public Health departments) that come in contact with individuals with addictions have become more prevalent. As these initiatives developed, new cross-agency program configurations also emerged. Although these collaborative programs seek to optimize the resources of the agencies involved to preserve the best interests of the client, they are often faced with differing philosophies, funding streams, and policies.

Substance Abuse Policy

Since the 1960s, Federal policy and legislation regarding the substance abuse treatment field have included a variety of drug abuse treatment and control bills. These include provisions for increased research in drug abuse, dependence, and prevention; policies for acceptable standards of care; legislation regarding the rehabilitation of those with narcotic addiction; legislation legalizing and regulating maintenance treatment; and a requirement for physicians who dispense methadone to be registered. By implication, all such acts, legislation, and laws have implications for the workforce, ranging from changes in education and training requirements, to developments in credentialing requirements, to changes in the demand for staff.

Federal drug control approaches have emphasized the importance of restricting the supply of illegal substances by conducting what has come to be known as the "War on Drugs." The Panel feels there remains an unmet need for funding to support addiction treatment programs and to support the development of the workforce (see Panel I Report).

Other social policy legislation also impacts substance abuse treatment staff. Recent examples include Welfare Reform and Drug Free Workplace legislation. With regard to Welfare Reform legislation, the incidence and prevalence of substance-related disorders among welfare program beneficiaries are fairly significant. The Panel feels that this will have a strong influence on the number, type, and skill mix of substance abuse treatment providers required. As a result of Drug Free Workplace legislation, growing numbers of employees are subject to random drug testing and are referred for mandated rehabilitation. Therefore, when considering workforce issues it is also important to understand Federal legislation that is not substance abuse-specific.

The Panelists believe that, too often, discussion of substance abuse issues at Federal and State levels is not well connected. The number of policy discussions that take place at multiple levels impedes cohesive debate on the problems of the substance abuse field. Further, the fragmentation of policy discussions hinders the development of cohesive national approaches to support the profile and objectives of the substance abuse field.

Although much of the general substance abuse policy and legislative agenda is relevant to or will indirectly impact the workforce, shortage of quantitative workforce data to inform discussion hampers policy debates focusing specifically on workforce issues. As a result, legislative and policy decisions cannot be made on comprehensive empirical data, and workforce issues can only be addressed using what experience tells us. Furthermore, there is no Federal office or department that has a comprehensive, nationwide picture of the substance abuse treatment workforce or that has responsibility for workforce policy development.

Financing

The financial structure of the substance abuse treatment field has fluctuated as the healthcare environment has changed, funding from managed care organizations has become available, and government policy regarding illegal substances has developed. The principle funding streams[2] for provision of public substance abuse treatment currently include the Substance Abuse Prevention and Treatment (SAPT) Block Grant; Medicaid funds; treatment dollars from the Indian Health Service; Federal funding for specific initiatives (e.g., the Department of Education's Safe and Drug-Free Schools program, and Drug Court and prison treatment funding from the Department of Justice); and, finally, State and County General Funds. For private substance abuse treatment, funding sources include insurers and/or third-party payors and self-pay clients.

All public funding streams have several characteristics in common. Funds are intended to resource the delivery of substance abuse treatment in the field; therefore, there are no individual funding streams that are intended specifically for the development of the workforce (and only a small portion of the Block Grant allocation is intended for workforce development). As a result, funding for workforce initiatives (recruitment, retention, credentialing, training or continuing education) has to come from treatment service dollars. To further complicate the picture, some of the funding the field receives is categorical, which reduces the pool of available program funds that workforce initiatives can access. Indeed, Panelists noted that providers in rural, remote, and culturally distinct or under-resourced areas might not be able to access private funding streams at all because their limited infrastructure has prevented them from building service capability and from addressing the credentialing requirements of these payors.

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[2] In some states, there also might be small amounts of income from specific State or local programs (e.g.,Temporary Assistance for Needy Families [TANF], Welfare to Work programs) or monies specifically targeted at the dual diagnosis population and various trust funds. However, these income streams provide insignificant amounts of revenue.

At the local level, the lack of a specific budget item for the workforce in treatment programs results in the needs of staff competing with the needs of clients. The basic development needs of staff are often threatened by multiple calls on limited revenue. For example, program administrators often have to make prospective or retrospective decisions regarding how program dollars will be allocated. In many cases, administrators can either invest in staff development or in other resources for the program, but frequently expenditure on both is not viable. Consequently, many of the daily budgetary decisions that State substance abuse directors, program directors, and administrators make affect the development of the substance abuse treatment workforce.

Technical and Clinical Developments

Technical developments prevalent in the substance abuse treatment field in recent years impact the curricula, education, training, and clinical practice of substance abuse treatment staff. In *Slaying the Dragon*, William L. White (1998) outlines some important technical developments in the substance abuse field in the last 50 years. Specifically, with regard to improving access to the treatment system, substance abuse treatment staff have made use of Employee Assistance Programs and formal family intervention approaches, as well as further developing outreach services to link potential clients to the system as early as possible.

Programs have made use of case management to manage all client needs including multiple diagnoses and/or high levels of acuity. Other patient management strategies have been implemented to deal with the individual and social risks associated with addiction. The development of client screening and assessment instruments to standardize diagnosis, referral, and treatment planning processes has been significant in recent years. Further, there has been a growth in outcomes research and other efforts to evaluate the clinical benefit and cost effectiveness of various treatment modalities, interventions, and program combinations.

Some of the treatment modalities that have been seen in the last 50 years include the systematic application of relapse prevention and relapse intervention technologies, the organic development of a variety of different types of recovery homes for post-treatment clients, the use of therapeutic drugs and other medications, and the formal incorporation of the family into treatment plans to strengthen a client's family support system. Overall, there has been a gradual transition from single treatment modality programs to the use of multiple levels and types of care in a client's treatment plan.

The introduction of computer- and web-based technologies to the substance abuse treatment field has been noticeable in very recent years, including using computers for client screening and assessment and distance learning technologies for staff training and continuing education.

Although these developments range from changes in clinical practice to the introduction of management information systems, all have one characteristic in common: These technologies require staff to learn new skills and competencies and to implement new practices. Thus, strategies and processes for basic and continuing education, curriculum development, and credentialing requirements, as well as for the supply of and demand for staff should be influenced by recent technical developments, where appropriate.

Workforce Attribute

The diversity of staff backgrounds and skills in the workforce results in a complex mix of staff characteristics, which confounds attempts to identify broad attributes for the field as a whole. However, during the discussion and analysis, Panel members identified some specific attributes, which are reproduced here.

One of the strengths identified early in the Panel process was the considerable knowledge and experience of those staff and faculty who have worked in the field for many years. The value of those with more than 20 years of experience is immeasurable, and these individuals are the backbone of the existing faculty of addiction professionals, providing valuable educational, clinical, administrative, and political leadership.

The unique contribution that recovering staff bring to the treatment field, both to clients and other staff members, was identified repeatedly as an asset that must be preserved. This contribution includes the ability to empathize and provide support from the recovery perspective, knowledge of street culture and vernacular, experience with Alcoholics Anonymous and Narcotics Anonymous, ability to serve as a role model, and extensive commitment and loyalty to the field.

Despite the lack of formal national standards for training, education, and credentialing the work that was done on developing Technical Assistance Publication (TAP) Series 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, is seen as a valuable resource for the field. The TAP Series 21, is considered in some States to be the current customarily accepted model of knowledge and skills required for competency. Its trans-disciplinary foundations and broad relevance make it an invaluable reference for the substance abuse treatment team as well as for all other professionals who work with clients with substance use disorders.

In the evolution of clinical practice, case managers and field staff who work in under-resourced, rural, or isolated areas are developing more differentiated practice patterns. Staff are broadening and increasing their skills, knowledge, and competency to function effectively at various levels of practice. This evolution has been necessary to treat the diverse and complex needs of clients in these under-resourced areas, which include different levels of client acuity, multiple co-occurring disorders, and the complex social needs of the various client groups. As client needs become more varied and multifaceted, this flexible and multi-skilled staff model is extremely useful.

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VII. Glossary

CLIENT-FOCUSED: Treatment that addresses the client's clinical needs, plus the client's perceived needs, goals, and agenda.

COMPETENCY: Knowledge + Attitudes + Skills. Implies application (i.e., counselors might be competent but fail tests; physicians might be knowledgeable but not competent).

CREDENTIALING: Licensing, certification, or registry process by which an individual can provide services in a specified professional capacity.

HEALTHCARE TEAM: Counselors (recovering staff and others), addiction physicians, addiction nurses, case managers, social workers, psychiatrists, psychologists, pharmacists, and other direct care and service providers.

RECOVERING STAFF: Degreed or non-degreed counselors working in the substance abuse treatment field who are in recovery.

PROFESSIONAL VS. OTHER STAFF: *Professional Staff:* Trained, educated, credentialed individuals treating addiction. *Other Staff:* Non-credentialed individuals, providing services to individuals with addiction.

STANDARDS: Statement or criteria that defines: (1) the level of requirement, excellence, or attainment, and (2) recommended minimum practice. Commonly used and accepted as an authority in a professional field. (Some might conform to an established norm.) Adherence to standards can serve as a measure of quality.

SEAMLESS: Treatment system without gaps or breaks in service, such that clients transition smoothly and with ease from one treatment component to another.

SUBSTANCE ABUSE: Problematic use of a substance to modify or control mood or state of mind in a manner that is illegal or harmful to oneself or others.[3]

WORKFORCE: Practitioners in a variety of related disciplines, for example, counselors, physicians, nurses, psychologists, social workers with varying levels of education, training, experience, and credentialing, who intervene in the lives of people with substance use disorders.[4]

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[3] http://www.nida.nih.gov/Diagnosis-Treatment/Diagnosis2.html

[4] Ibid.

Section II: Public Hearing Summaries

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I. Overview

As part of the National Treatment Plan Initiative (NTP), the Center for Substance Abuse Treatment (CSAT) convened six public hearings in order to ensure the incorporation of community perspectives in the NTP efforts to improve the availability, accessibility, and quality of substance abuse treatment services across the nation. The hearings were held in geographically diverse areas in order to receive testimonies, both oral and written, from a wide variety of individuals and organizations involved with and affected by alcohol and drug problems. Over 400 testimonies were heard from individuals from 31 States. Hearings took place in Arlington, Virginia; Hartford, Connecticut; Chicago, Illinois; Washington, DC; Portland, Oregon; and Tampa, Florida, between June and November, 1999.

The public hearings provided an opportunity for CSAT and all agencies involved in the NTP Initiative to listen to issues of concern to clients, staff, and other stakeholders in the substance abuse treatment system. Major themes included:

- The need for the field to consider the impact of multiple and overlapping stigmas and to educate the public about the disease of addiction.
- The need for an increase in funding to support the improvement of treatment.
- The need for integration with other systems, such as the primary care, mental health, child welfare, justice, and social services systems.
- The need to: (1) develop common language around alcohol and drug problems among criminal justice, mental health, and substance abuse communities; (2) classify addiction as a disease; and (3) reimburse treatment expenses as a medical condition.
- The need for better access to treatment in order to ensure that treatment is administered at defined quality standards. The need for increased communication between the service delivery and research communities to ensure the dissemination of best treatment practices.
- The need for training and education in substance abuse treatment to be evidence-based and culturally competent, and that trained and educated staff are certified and licensed using a unified, national system.
- The need to address workforce shortfalls by making substance abuse treatment salaries commensurate with other health professional fields, by supporting the education of new and existing counselors with scholarships, stipends, and loan forgiveness, and by establishing a career ladder within the field.

II. Hearing Summaries[1]

A. ARLINGTON HYATT, ARLINGTON, VIRGINIA, JUNE, 30, 1999

On the evening of June 30, 1999, the Center for Substance Abuse Treatment (CSAT) — a component of the Substance Abuse and Mental Health Services Administration (SAMHSA) — held a hearing in conjunction with a four-day grantee meeting. This short hearing was a prelude to a series of one-day public hearings that constitute a crucial component of CSAT's initiative, *Changing the Conversation: The National Treatment Plan Initiative (NTP)*. Input from these hearings, combined with recommendations from expert panels, will serve as the foundation for the NTP that will guide national programs and policy. The hearing was organized into the same five domain areas addressed in the NTP Initiative: closing the treatment gap, reducing stigma and changing attitudes, improving and strengthening treatment systems, connecting services and research, and addressing workforce issues.

Johnny Allem moderated the hearing, and H. Westley Clark, Camille T. Barry, Andrea Barthwell, and Susan Thau served as expert panelists. Twenty individuals presented testimony, some testifying on more than one domain. The following summarizes their recommendations, concerns, and other comments.

Closing the Treatment Gap

Generally, those who testified expressed a need for increased access to treatment across the continuum of care and for funding that is commensurate with the need for treatment. People commented repeatedly on the way in which managed care has constricted treatment provision. In addition, some argued that treatment should be available on demand and that anyone who is Medicaid-eligible should have access to treatment services. Some also called for increased attention to the needs of special populations, including those involved in the criminal justice system, people with disabilities, Native Americans, transgender clients, lesbian and gay clients, and adolescents. One person recommended that recovery support services be recognized as a distinct part of the continuum of care and called for increased availability of such services provided by persons in recovery. Another person commented that planning for the services across the continuum of care could be improved by more thorough needs assessments.

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[1] Hearing Summaries were prepared by ROW Sciences, Inc. under contract to CSAT. The content of this document represents the ideas of those who presented testimony and does not necessarily reflect those of CSAT or SAMHSA. Lists of participants and affiliations of hearing panelists are included in Section III, *Participant Acknowledgements*.

Reducing Stigma and Changing Attitudes

According to those who testified, the public tends to view addiction as a moral issue rather than as a disease. Suggestions for shifting this perception included educating the public about research on brain chemistry; developing a "common language" among the Department of Justice, mental health agencies, and the substance abuse community; and replacing the term "substance abuse" with a term that more accurately reflects the nature of the disease, such as "addiction." One person who testified stressed that effective recovery must address issues concerning stigma and the client's shame and low self-esteem.

Improving and Strengthening Treatment Systems

Testimony indicated that CSAT's block grant funding mechanism does not facilitate coordination and collaboration at the local level and, therefore, should be modified. In addition, it was suggested that CSAT form partnerships with the Indian Health Service to assist tribal governments in obtaining additional money to maintain and increase the number of treatment beds for Native Americans.

Connecting Services and Research

One person who testified called for ethnographic case studies and additional surveys targeting consumers and families. Another recommended enhancing the user-friendliness of research so that findings can be shared with and understood by a broad audience. Other testimony suggested that people in recovery should be consulted when programs are considering how to apply treatment approaches that appear to have been effective in research settings.

Addressing Workforce Issues

According to some who testified, the number of people in recovery who are providing services is decreasing because of changes in certification and licensing requirements and the shift to managed care. Recommendations to CSAT for reversing this trend include using block grant money to influence the staffing of treatment programs and advising programs about how to maintain a balance between professional staff and staff who are in recovery. In addition, policymaking decisions and grant implementation should include front-line staff.

A recurring theme throughout the hearing was that CSAT and the treatment field should respect the voices of people in recovery in the development of the NTP. Moreover, those in recovery should be surveyed for their thoughts on addiction and recovery and should be included in policy- and decision making processes. One person who testified recommended that CSAT provide recovery organizations with the opportunity to carefully review the body of work that evolves during the development of the NTP. Another person expressed concern that the public hearings were not scheduled in locations accessible to members of treaty tribes. A solution to that problem would be that CSAT provide a forum for contributions from treaty tribe members.

B. STATE CAPITOL, HARTFORD, CONNECTICUT, JULY 8, 1999

On July 8, 1999, CSAT held a one-day public hearing to offer the general public the opportunity to contribute to the NTP Initiative. Dennis McCarty moderated the hearing, and H. Westley Clark, Albert J. Solnit, Thomas A. Kirk, Camille T. Barry, Linda Kaplan, Thomas Edwards, Jr., José A. Rivera, Constance Horgan, Lisa Nan Mojer-Torres, John Coppola, Ronald White, and Andrea Barthwell served as expert panelists. Seventy-six individuals presented testimony, some testifying on more than one domain. The following summarizes their recommendations, concerns, and other comments.

Closing the Treatment Gap

Of the issues that emerged during the testimony on closing the treatment gap, perhaps the most pervasive involved the needs for expanded treatment capacity, including more treatment slots and longer lengths of stay for all people, but, especially for special populations including youth, criminal offenders, and women with children. A substantial focus was placed on managed care's contributing to the gaps in treatment and the degree to which treatment is unavailable. Solutions for increasing capacity included increased funding for treatment and passage of legislation for substance abuse treatment parity.

Several of those who testified called for increased funding for and availability of recovery support services and recognition of these services as a distinct part of the continuum of care. Recovery support services, which include assistance in entering various levels of treatment, locating housing, and securing employment, bridge the gap between treatment and the community.

Testimony indicated that gaps in treatment are especially problematic for certain populations who need access to multiple systems of care or who are at high risk of relapse. For these individuals, a multi-system, multidisciplinary approach was suggested as the way to provide comprehensive treatment. For example, effectively addressing the specific needs of women with children may require close collaboration between a caseworker from the State's department of children and families and a substance abuse treatment provider, along with involvement of a counselor — who can address issues related to physical abuse — and a physician who can provide primary care. Comprehensive treatment for the family may require job skills and parenting skills training, child care, treatment for related issues (e.g., low self-esteem), and housing and transportation.

Some people testified that the gaps between systems could be minimized by initiating a coordinated approach for addressing substance abuse on the Federal level.

Several recommendations were presented for specific populations:

- For adolescents, create a continuum of care that addresses their development and the family crisis that results from addiction; develop and adopt criteria specific to teens that can be used as standards for residential care; provide respite care for adolescents away from their families; educate parents, communities, and health professionals about drugs and addiction; encourage schools to confront substance use and abuse by students; and establish an accessible information and emergency counseling hotline.
- For homeless clients, some of whom also have mental illness, increase access to transitional housing and permanent supportive housing to help them move from emergency shelters to treatment and from treatment to recovery.
- For women and women with children, increase the special programs and education, research, and treatment that address their specific needs; increase the availability of safe, affordable housing and recovery homes; and fund programs that use family-focused interventions.
- For criminal offenders, increase the number of diversionary treatment programs; educate correctional officials about the efficacy of treatment; and eliminate statutory, programmatic, and economic barriers that make incarceration the first course of action to manage substance-abusing offenders instead of treatment.
- For "the working poor," ensure that they have adequate access to services. This group is rapidly losing insurance, and those that are able to purchase services themselves rarely buy packages that include a behavioral component.
- For undocumented clients, ensure that they have access to services regardless of their immigration status.

Reducing Stigma and Changing Attitudes

People testified that the stigma against individuals with addiction contributes to denial, prevents individuals from receiving the treatment they need to recover, forces persons in recovery to live in fear of "being discovered," and impedes appropriate siting of needed treatment programs, especially methadone programs.

The primary recommendation for reducing stigma was to implement a multiyear, multilevel public education campaign to share facts about addiction. According to those who testified, the most important messages to share are that addiction is a disease, not a moral problem, and that addiction can happen to anyone. Addiction is treatable, and relapse is a part of the disease. Another important message to share is that substance abuse, mental health, and HIV/AIDS are tied to poverty. Suggestions for the public education campaign included modeling the campaign after product advertising, infusing drug education into all parts of the school curricula at all levels, and posting drug information on Government and school Web sites. In addition, there was agreement that people in recovery have a role in reducing stigma by telling their own stories, which "puts a face on addiction." People in recovery could share their stories in classrooms, public service announcements, and chat rooms. In addition, people in recovery should take a greater role in advocacy and political activism.

Several policy approaches were recommended for reducing stigma. The most important one was passing the substance abuse parity act. In addition, some recommended enacting welfare reforms that treat rather than punish those with addiction and that recognize the long-term efficiency of early identification and treatment, removing legal restrictions to treatment, and enhancing the ability to prevent and deal with the consequences of tragedies related to substance abuse.

Some people who testified charged the field with reducing stigma. They suggested that, first, those in the field should avoid using language that contributes to stigma, such as the term "substance abuse," which supports the idea that addiction is caused by willful misconduct. Second, treatment providers should avoid criticizing treatment approaches used by other providers, because such criticism diminishes the credibility of the whole field. Mandatory training and education about the physiology, psychology, and sociology of addiction were recommended for program staff.

Finally, people called for more research that demonstrates the efficacy of treatment as a way to decrease stigma. Data on what works and for whom should be made available to the public-at-large, including families and policymakers. Data also should be shared with other systems, especially the criminal justice system, which does not adequately embrace treatment as an important crime fighting and disease-reduction tool.

Improving and Strengthening Treatment Systems

In the words of one person who testified:

> *"Substance abuse treatment works best when it is coordinated and when it becomes a system of care which is capable of addressing the often complex needs of the total individual. It is rare that a single entity has the resources and expertise to address the medical, psychological, housing, vocational, educational, transportation, access, and cultural needs of any particular client. The challenge . . . for substance treatment providers is to build a system of care through collaborations with other providers that can address the very needs of clients without making them negotiate multiple layers of bureaucracy."*

This theme was echoed throughout the day of testimony. Other testimony indicated that because systems often coexist in isolation, treatment dollars are not used effectively and the quality of treatment suffers. Connecting systems can be extremely important for clients with co-occurring addiction and mental illness, drug-involved criminal offenders, homeless clients, and women with children. It also was suggested that integration of services across systems would be enhanced by independent case management and by a policy that ensures that patient records can be shared adequately and effectively across all systems.

A primary recommendation for integrating services was that State and Federal governments should encourage collaborations in both the public and private sectors through funding mechanisms (e.g., funding collaborative efforts, avoiding the use of funding mechanisms that require agencies to compete with one another). In addition, these governments should change laws or policies that obstruct the development of these systems of care. Effective collaborative efforts could be promoted as models in other States.

In spite of the need to collaborate across systems, some people argued against merging the funding streams for substance abuse and mental health services to avoid a possible decrease in substance abuse treatment services and a loss of identity for the field. In addition, some recommended using caution in making "sweeping" changes.

Examples of other recommendations are the following:

- Improve cultural competence in all behavioral health services at the service delivery, administrative, and policymaking levels.
- Take a more comprehensive approach to data gathering that includes providers of services in both the public and private sectors.

- Develop a national consensus among the private and public sectors regarding treatment definitions and measurements of results.
- Increase the accuracy and consistency of data on patient census and waiting lists.

Connecting Services and Research

According to testimony, there is and has been a "disconnect" between those who conduct research and those who put it into practice. Generally, efforts are needed to ensure that new knowledge gained in research is disseminated and implemented effectively in the clinical setting. Likewise, efforts are needed to ensure that the most pressing challenges and most promising practices in treatment programs are being studied by researchers. It also was suggested that practices shown to be effective and cost-saving be communicated to lawmakers.

Several people who testified described projects that address the implementation of research, including practice/research collaborations and Connecticut's Statewide Clinical Treatment Innovations Network, which systematically assesses whether treatments shown to be effective in "ideal" settings can be effective when applied more generally by clinicians. One person who testified recommended that CSAT consider the development of State university academic partnership grants to develop partnerships between university-based researchers who conduct research on treatment and single State agency directors who disseminate and implement research findings.

Several people who testified commented on the application of specific areas of research (including research on office-based methadone maintenance) and the need for specific types of research (such as research on the cost-benefit of treatment and research on the effect of new atypical anti-psychotic drugs on the treatment of severely addicted individuals).

Some other suggestions from testimony included the following:

- Outcomes measures should account for factors related to economic resources that are available to individuals — especially women — after treatment, such as jobs at a living wage, child care, affordable housing, transportation, and medication.
- A standardized set of measures for collecting data should be developed.
- Some of the funding available for scientific research should be directed toward application of research in the field.
- Demonstration grants and other funding for model programs need to encourage attention to anticipated major changes that will affect the substance abuse treatment system.
- Caution should be used in interpreting and translating research.

Addressing Workforce Issues

Three main areas of testimony were presented that related to workforce issues: the type of people providing treatment, the education of health care practitioners to increase substance abuse screening in the medical setting, and workplace policy and treatment for employees.

Those who testified frequently commented on their concern about the decreasing number of persons in recovery who are working as counselors in substance abuse treatment programs due to changes in certification and licensure, as well as the shift to managed care. One person recommended that CSAT direct funds from block grants to the States in such a way as to encourage State and individual treatment programs to increase the number of persons in recovery on their programs' staff. Another issue facing programs is the insufficient number of Spanish-speaking clinicians, nurses, physicians, and psychiatrists to respond to the number of Spanish-speaking clients who are served in treatment programs. It was suggested that CSAT support educational initiatives that would allow Spanish-speaking people to earn degrees in the helping professions. Another person who testified recommended that Federal standards for alcohol and drug counseling be instituted in order to protect consumers.

Some people testified that although alcohol and other drugs frequently contribute to injuries that are treated in emergency care and surgical practice, health care practitioners often fail to recognize and address alcohol and other drug problems in their patients. Therefore, it was suggested that health care practitioners' knowledge, beliefs, and attitudes must be changed with education and training about addiction and how to address the disease.

Testimony was also heard regarding the need for developing workplace programs that prevent substance abuse and achieve drug-free workplaces. Addressing substance abuse issues is especially difficult for small businesses, which require educational and training opportunities to increase awareness. Testimony also reflected the importance of businesses having not only an employee assistance program but also appropriate insurance so that employees have access to needed services.

Other Issues

A recurring theme throughout the hearing was that CSAT and the treatment field should listen to the voices of people in recovery in the development of the NTP and, more generally, develop a process by which consumers can be consulted regularly as full partners in the recovery process.

C. LOYOLA UNIVERSITY, CHICAGO, ILLINOIS, SEPTEMBER 16, 1999

On September 16, 1999, CSAT held a one-day public hearing in Chicago, the third in a series of hearings providing input to the NTP Initiative. Testimony was heard in five NTP domains related to substance abuse treatment: closing the treatment gap, reducing stigma and changing attitudes, improving and strengthening treatment systems, connecting services and research, and addressing workforce issues.

Melody Heaps moderated the hearing, and H. Westley Clark, Lura Lynn Ryan, Nick Gantes, Susan Weed, Camille Barry, Michael Couty, George Gilbert, Benjamin A. Jones, Judith Lewis, and Chilo Madrid served as expert panelists. Sixty-five individuals presented testimony, some testifying on more than one domain. The following summarizes their recommendations, concerns, and other comments.

Closing the Treatment Gap

The foremost issue discussed during the hearing was the paucity of treatment available for those who need it. The inadequacy of resources, not only for providing treatment but also for ensuring quality treatment, also was cited. There were comments on the "disconnect" between the nature of addiction as a chronic brain disease and the fact that available treatment often consists of only of a few sessions in outpatient care.

A negative effect of managed care and health maintenance organizations (HMOs) on the ability to provide adequate treatment was mentioned by several speakers. They suggested that these organizations should give more consideration to symptomatology than to cost factors. Additionally it was suggested that outpatient treatment, which is the most intensive treatment that insurers will pay for under many health insurance plans, is not adequate for many patients, especially homeless persons.

The importance of providing services in recovery homes was mentioned by several people who testified. It was also noted that recovery services can be an important bridge between treatment and the community, especially for people whose homes and communities are not conducive to their recovery. Testimony included recommendations about the kinds of services that need to be provided during a long-term recovery period of up to 18 months, including aftercare and training in parenting, communication, and job skills. The importance of establishing recovery homes for teenage girls was emphasized. More than one speaker suggested that health insurance coverage be provided for persons requiring care in recovery homes.

Speakers indicated specific gaps related to treating women. According to some, there is a pressing need for services to treat women with their children and to provide care for infants and children who need special services because of parental addiction. An expansion of funds was recommended for the treatment of women and children that would include parenting and other education, vocational training, housing, and case coordination. Another speaker noted that many women need childcare to be able to take part in treatment. In addition, it was suggested that alternatives to incarceration are needed, particularly for female offenders.

Various testimonies suggested that new and different models are needed for treating adolescents, including those with co-occurring disorders; for coordinating their care; and for following through to ensure that their needs are met. Other populations for which treatment should be improved included dually diagnosed and offender clients, functional abusers who do not seek treatment, homeless people who cannot participate effectively in outpatient treatment, and welfare-to-work clients who need treatment during evening hours and on weekends due to their work schedules. Another speaker called for improved approaches for the treatment of male African American patients, including making recovery homes available to them.

Attention was given to the need to treat the medical conditions of many patients, especially those with sexually transmitted diseases (including HIV and AIDS) or hepatitis, and to the need for the primary health care system to take part in providing their care. Some people who testified called for increased awareness of the gang situation in Hispanic communities across the country and its relationship to drug problems, as well as the need for treatment staff who are Hispanic or from other ethnic minority groups.

The importance of the continuum of care and the ability of any individual in need to receive all levels of care was also emphasized. Testimony addressed the need for shared patient information across providers and systems (e.g., ancillary service providers, criminal justice). The view was expressed that incarceration in the correctional system should not be the prescription for people who are nonviolent; treatment alternatives can be offered to these people with addictions.

Reducing Stigma and Changing Attitudes

Numerous speakers highlighted the power of recovery and the need for members of the recovery community to speak about addiction and their experiences in an effort to help others understand the nature of the disease. The belief was expressed that the recovery community can play a very important role in changing attitudes about addiction and about people with addiction.

Appeals from various speakers showed how stigma distorts public policy, can contribute to the inappropriate incarceration of people with addiction, and can have a negative effect on child welfare when parents are separated from their children. People in recovery clearly described the stigmas and societal attitudes they faced in seeking treatment and remaining in recovery.

According to some speakers, there is an urgent need to address the impact of racism, sexism, and economic oppression on public policies regarding treatment. Speakers noted the differences between communities in which addiction is addressed through the criminal justice system and communities in which it is addressed by health care. Unfortunately, they said, current public policy accepts that people who have money and stable jobs have disproportionate access to the rare inpatient treatment programs.

Several speakers saw a need for CSAT and other government spokespersons to provide information about addiction and treatment that would change attitudes among several key groups: treatment providers, regulators, physicians, administrators of health insurance and managed care systems, and members of the criminal justice system. Key messages should include that treatment works and that addiction is a chronic and relapsing brain disorder. Government spokespersons also should advocate for substance abuse training for individuals in medical schools, nursing schools, and other professional schools.

Testimony suggested a particular need to publicize the effectiveness of methadone treatment for people addicted to heroin. Speakers suggested that when members of professional groups and administrators of health insurance and managed care organizations limit substance abuse treatment, they negatively influence public thinking about effective treatment and what it should entail. One speaker believed that participants in the War on Drugs and the criminal justice system should focus on positive attitudes.

Improving and Strengthening Treatment Systems

Testimony was presented about the need to understand how to treat clients who have multiple needs on the basis of factors such as gender, culture, and health status. CSAT can provide leadership to treatment providers with respect to the treatment of patients with co-occurring disorders and complicated medical problems, as well as other special populations. The treatment system must be able to respond to their needs.

Some people testified that substance abuse treatment should be considered the same as treatment for any other medical illness by insurers. They suggested that CSAT monitor and evaluate managed care to help its practitioners change their decision-making logic.

Speakers emphasized the importance and need for linkages across systems. Treatment staff need to be engaged in developing systems integration strategies. In addition, some speakers called for improved wraparound services as a major focus in treatment. They talked about including empowering, strengths-based approaches in treatment programs and including housing, employment, education, and parenting services as central, not peripheral, components to treatment. Bridges among disciplines are needed, and it was suggested that CSAT help to establish them.

Others suggested that CSAT develop a prototype of an interdisciplinary, comprehensive system of care for adolescents, generating research data, replication, evaluation, and continued funding. CSAT also should provide information on adolescent care to policymakers to improve their understanding of effective treatment and recovery services for this population.

Testimony was presented on legalization and regulation of drugs for adults, and harm reduction was discussed. Speakers noted that some people who can benefit from treatment may not be ready for abstinence. However, they recommended that these individuals be permitted to enter treatment; their early stages of treatment could concentrate on building motivation for further change.

Two speakers suggested that the role of preventionists should be expanded and that they should be educated to identify clients for treatment. In particular, preventionists can serve as outreach workers to identify youth and refer them for assessment and treatment. With adequate funding, preventionists can promote positive peer interaction, social skills development, conflict resolution, and positive alternative activities for youth.

The importance of identifying and applying best practices was emphasized. With respect to best practices, one speaker suggested that seven- to ten-day detoxification be provided for late-stage alcoholics and addicts. Once the patient enters treatment, treatment needs to be available for relapses, accidents, infections, and cirrhosis. A physician pointed out that the restoration of health during treatment and recovery will help eliminate the costs of later complications. There were many comments on methadone maintenance and how stigma influences its administration, there by preventing the implementation of known best practices. The concept of making methadone maintenance part of mainstream medical care and the problems inherent in doing so were discussed.

Connecting Services and Research

Testimony indicated that clinicians on the front line in treatment programs need to understand the latest research findings and how research is conducted. Mechanisms and funding need to exist to facilitate staff training to advance their knowledge in these areas. Currently, staff are limited in their ability to participate in training because programs are reimbursed only for time spent providing direct service.

Barriers to conducting research on best practices were identified. To connect research with practice, research needs to be conducted with poly-drug users and those with multiple dysfunctions or disabilities, who are typically seen in real-world settings. Others stated that it is important for researchers to consider the pattern of clients' entire lives.

Other testimony indicated that community-based agencies and practitioners need to take part in identifying appropriate research questions to ensure that research produces findings that they can apply in their work. The need to establish mechanisms to involve treatment personnel in the formulation of research goals, and the parallel need to improve the dissemination of research results to them, was addressed several times.

Some speakers called for funding for creative and innovative research that leads to new approaches in treatment. The idea was presented of an "imagining" center that would conduct research on the possible range of medical, neuropsychological, and psychological services. In addition, a great need exists for an infrastructure for substance abuse research that is based on the medical model of research. Finally, it was suggested that certification and licensing bodies examine ways to ensure that clinicians and programs are keeping informed about and are implementing best practices.

Addressing Workforce Issues

Testimony was presented along two tracks. The first track related to the ways in which small businesses, large companies, and industries deal with people who use alcohol or other drugs or who are in recovery. This testimony spoke to the need to establish company policies that encourage Employee Assistance Programs (EAPs) and treatment interventions. In addition, it was suggested that companies should be better educated about how EAPs and substance abuse programs can improve productivity. There is a need to gather new data regarding substance abuse in the workplace and a need to carry a succinct message to employers about their role in helping their employees.

Speakers presented their understanding that the country's dysfunctional workforce derives in part from the fact that substance abuse goes untreated. However, the workplace represents an opportunity for intervention; the substance abuse treatment field should support and seize this opportunity. The need to address the dysfunctions of the workforce that are related to substance abuse and resulting problems applies not just to business, industry, and retailers, but to human service agencies as well.

The second track addressed issues in the workforce composed of providers in the substance abuse treatment and prevention systems. Radical changes have occurred in substance abuse and treatment over the last 10 to 15 years, and treatment personnel are not necessarily trained to address these changes.

Speakers stressed the need to ensure that treatment programs have an appropriate staff in place. Program staff must have the expertise required to receive funding and reimbursement for services, must be appropriately multicultural and multilingual, and must be aware of myriad psychosocial and interdisciplinary treatment approaches. Training and other educational opportunities must be made available to both professional and nonprofessional staff members.

One issue raised is the need for a role for nonprofessional community people, who may enhance many clients' treatment or recovery but lack formal training.

D. METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS, WASHINGTON, DC, OCTOBER 18, 1999

On October 18, 1999, CSAT held a one-day public hearing in Washington, DC, the fourth in a series of hearings that constitute a crucial component of CSAT's NTP Initiative. Testimony was heard for each of the five NTP domains: closing the treatment gap, reducing stigma and changing attitudes, improving and strengthening treatment systems, connecting services and research, and addressing workforce issues.

Peter F. Luongo moderated the hearing, and H. Westley Clark, Camille T. Barry, Guardia E. Banister, Alpha Estes Brown, Karen Dale, Thomas Davis, John Gregrich, Patricia D. Hawkins, Elvin Bernard Parson, Melanie Randall, Dedra Roach, Michael C. Rogers, and Sue Thau served as expert panelists. Seventy-five individuals presented testimony, some testifying on more than one domain. The following summarizes their recommendations, concerns, and other comments.

Closing the Treatment Gap

The comments provided by the first person who presented testimony set the tone for the rest of the hearing, stating that substance abuse treatment is in search of recognition and acceptance in public policy and advocacy at the highest levels of Government. Every one of the Nation's social systems is affected by the continuing epidemic of substance abuse, a problem that is exacerbated by the paucity of substance abuse treatment. He found it hard to believe that treatment is not a top Government priority.

Speakers in this domain noted that treatment is not available or accessible to hundreds of thousands of people who need it, many thousands of whom reside in the Washington metropolitan area alone. CSAT was asked to address particular gaps in programming, including treatment programs for adolescents; programs integrating substance abuse and mental health treatment for persons with co-occurring disorders; programs for women and their children; programs for persons with both HIV infection or AIDS and substance abuse disorders; programs addressing the needs of people with substance abuse problems who are dealing with issues of sexual abuse and violence; and comprehensive programs, such as therapeutic communities. Particular attention was directed to the need for specialized substance abuse treatment programs for adolescents, as well as the need to find ways to make adolescent treatment more affordable to families.

One glaring gap in treatment that was noted was the lack of programs that serve people who are deaf and have substance abuse problems and the lack of treatment staff who can understand and proficiently use sign language.

Speakers highlighted the gaps in auxiliary services related to substance abuse treatment, including family services, violence intervention, services related to sexual abuse, housing, parenting, and employment. Attention was directed to the need for additional services addressing transitional housing, job preparation, and the employment needs of clients during the important recovery period immediately following treatment. Also emphasized were the needs of welfare-to-work clients who are able to find only minimum-wage jobs and need drug-free transitional housing during recovery so they can avoid returning to their old neighborhoods and communities, which may not support their sobriety. Others commented on the difficulties faced by single women who must pay for child care during the search for jobs and initial employment, often at meager wages, while staying free of drugs and alcohol. Testimony suggested that CSAT might facilitate co-location of substance abuse treatment services with the offices responsible for welfare-to-work programs, since substance abuse is commonly present in the welfare-to-work population.

The establishment of community-wide systems for accessing treatment and community-wide referral systems was recommended, with a single agency coordinating entry to treatment and facilitating referrals.

Problems with insurance carriers limiting access to treatment, such as the refusal of some insurers to pay for certain treatment modalities, were described, along with the need for full parity of treatment for substance abuse with treatment for other physical conditions in insurance plans.

CSAT was asked by several speakers to help increase the skills of treatment providers in supporting the newly emerging recovery community, helping it develop the advocacy skills needed to draw attention to the need for treatment. Some speakers suggested that the Recovery Community Support Program be expanded. A related theme throughout the hearing was the importance of involving people from the recovery community in the design of treatment approaches.

Testimony addressed the growing rate of Hepatitis C among the substance abuse treatment workforce and among clients. Testimony called upon the National Institutes of Health, SAMHSA, and other appropriate resources of the Department of Health and Human Services to confront this epidemic.

According to the testimony, it is very important that people be able to enter treatment when they determine that they need it. In many geographical areas this is impossible. In some cases, no programs have treatment slots available. In other cases, insurance carriers prevent access to treatment because they only pay for specified modalities or they misunderstand issues such as relapse.

Reducing Stigma and Changing Attitudes

A major theme that emerged in the testimony was the need to overcome practices of treatment providers that promote rather than help remove the stigmas attached to substance abuse, such as perpetuation of the idea that treatment is punishment and that persons with this illness are "bad," rather than sick. A related suggestion was to eliminate the term "substance abuser," which is seen as dehumanizing, political terminology. Medical terminology is needed that more accurately describes the illness and the ill person.

One speaker suggested that a Federal commission root out policies and laws mandated in all Federal agencies that are based in stigma. Interstate and national programs and media campaigns to advocate for the field were recommended to educate the public about the need for changed thinking regarding stigma. In addition, the inclusion of communications specialists within the field should be considered.

Another speaker suggested that a New Jersey model of State councils be implemented to advocate for the treatment field and influence policy and legislation. One reason it was easy for managed care organizations (MCOs) to remove substance abuse treatment from coverage was because the public was not sure substance abuse treatment was needed, and State councils could help the public better understand substance abuse and treatment. Treatment providers are now shouldering responsibility for public education, and their attention needs to be devoted to clinical and administrative issues, particularly in a time when managed care requires so much administrative attention.

Speakers also noted the difficulties in finding employment that are faced by persons who have been incarcerated for substance-related offenses and have completed their sentences, and they asked for help in addressing this issue by directing attention to the successful rehabilitation of such persons.

Other testimony addressed the stigma that exists against traditional counselors who are in recovery and who have contributed to the care of persons in treatment. These persons should be heard from regarding the establishment of educational and credentialing programs for counselors.

Another speaker highlighted the institutional stigma that keeps emergency room and trauma centers from testing injured patients for the presence of alcohol and drugs and from using a positive finding as a basis for intervention.

Improving and Strengthening Treatment Systems

Several areas for improvement were highlighted: treatment of dually diagnosed patients, treatment of clients returning to work from welfare, culturally sensitive treatment for Latinos and other groups, methadone maintenance, treatment for patients with HIV/AIDS, and treatment for people who have been sexually abused. In addition, speakers called for removal of bans against needle exchange programs, which can prevent AIDS without increasing substance abuse.

CSAT and the Center for Mental Health Services (CMHS) were called on to collaborate in finding ways to enable providers in their two fields to integrate their services and work jointly with individual patients; a mandate from the two agencies requiring collaboration was suggested. Similarly, CSAT was asked to work with other agencies to ensure that comprehensive services, including substance abuse treatment, are available for people who are on welfare and are moving out of welfare. The need to educate treatment providers about dual diagnosis was noted. This includes the need to educate mental health providers about substance abuse treatment.

Others remarked on the discrepancy between scientific knowledge about the successful use of methadone in treating opioid addiction and practices in the field. CSAT was asked to direct attention to this issue.

Programs in which community residents have helped design culturally sensitive treatment, particularly in Latino communities, were described, and the replication of this approach was recommended. The use of telecommunication systems to provide continuing education for workers in rural areas and to present educational components of treatment in these areas was suggested.

Speakers mentioned other areas that need to be improved and strengthened, including insurance parity, outcomes research, and length of treatment stay. Another recommendation was to conduct research on breathwork, a novel approach to treatment that has been studied and shown successful.

Connecting Services and Research

CSAT was asked to continue its interactions with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to ensure that their research findings are made available to treatment providers. In particular, information on research results need to be made available to counselors. Testimony indicated that CSAT also can play a major role in ensuring that research results are implemented locally. One speaker advocated for a comprehensive Federal training and technical assistance program to advance research utilization, extending beyond the scope of Addiction Technology Transfer Centers.

Grassroots research, in which local programs participate, was recommended. One person called this "in-field" evaluation that could be supported by temporarily stationing researchers in community-based organizations.

Addressing Workforce Issues

Recommendations pertained to the treatment workforce, education about substance abuse problems in the Nation's workforce, and problems of women on welfare entering the workforce.

It was suggested that CSAT provide technical assistance and training to enable the substance abuse treatment workforce to keep abreast of advances and new findings in the field. Other speakers recommended that attention to standards of care not exclude recovering staff who can assist clients in recovery or prevent people from entering the field as entry-level counselors. Scholarships and grants for the education and training of traditional counselors could be provided, and attention could be directed at better integrating counselors into the health care system.

It also was suggested that, to address the shortage of trained professionals in substance abuse treatment, a strategic planning process should be initiated that includes the private vendor sector. In addition, there should be a sharing of resources between the private vendor sector and Government agencies with respect to expertise and technology.

Many people leaving welfare rolls to seek employment need substance abuse treatment, and it was noted once again that their needs for treatment and auxiliary services should be met. The need for treatment models oriented to helping women prepare to return to work was stressed; counseling that deals with their work-related issues was recommended.

Speakers called attention to legislation in Virginia that would keep recovering addicts with certain criminal histories from working in substance abuse treatment programs. Vigilance is needed in addressing this problem and in influencing discussions of such legislation proposed elsewhere.

E. THE PORTLAND BUILDING, PORTLAND, OREGON, OCTOBER 26, 1999

On October 26, 1999, CSAT held a one-day public hearing in Portland, OR, the fifth in a series of hearings that constitute a crucial component of CSAT's NTP Initiative. Testimony was heard on the five NTP domains: closing the treatment gap, reducing stigma and changing attitudes, improving and strengthening treatment systems, connecting services and research, and addressing workforce issues.

Victor Capoccia moderated the hearing, and Camille T. Barry, Mady Chalk, Barbara Cimaglio, Amalia Gonzalez Del Valle, Lewis E. Gallant, Steven L. Gallon, Melody M. Heaps, Alan Melnick, Rod K. Robinson, Kenneth D. Stark, and Flo Stein served as expert panelists. Eighty-seven individuals presented testimony, some testifying on more than one domain. The following summarizes their recommendations, concerns, and other comments.

Closing the Treatment Gap

The universal need for more treatment resources was best exemplified by the Director of the Oregon Department of Human Services, who stated that his department's staff of 10,000 could be reduced by 50 percent if the problem of addiction could be eliminated. Addiction is the most serious problem affecting clients, from prenatal to geriatric, in all the social services provided by the agency.

Lack of treatment programs is only part of the treatment shortfall. Gaps in resources needed to provide effective service are caused by numerous factors, including the failure of managed care providers to adequately reimburse, if at all, for substance abuse treatment. Individuals testifying stated that paperwork and bureaucratic requirements of managed care organizations take resources away from treatment and reduce the number of clients who can be served.

There was a call for CSAT to work with other parts of the United States Department of Health and Human Services (DHHS) to change the Medicaid requirement stating that funds for substance abuse treatment can only be provided for patients in facilities with 16 or fewer beds. This requirement keeps many patients from receiving treatment who would otherwise be eligible for it.

Speakers also called on CSAT to educate insurers regarding: (1) the rationale for parity of substance abuse with other conditions requiring medical care, (2) the need for higher reimbursement rates, (3) the need for employer health policies that cover more comprehensive services, and (4) the willingness of insurers to provide requested information about coverage to employees in these plans. Insurers also need to understand that reimbursing services only for individuals, despite the scientific evidence for the importance of family treatment, can reduce the effectiveness of treatment.

Numerous testimonies highlighted gaps in specific services, including methadone maintenance, services for numerous vulnerable populations such as minorities and persons with disabilities, outreach to Asian and Pacific Islander communities, adolescent substance abuse, and outreach to incarcerated and homeless Native Americans. Other gaps were noted in maintenance care following treatment, services for women with their children, treatment of co-occurring disorders among minority citizens, services for women in welfare-to-work programs, care of hepatitis C among addicted and recovering people, and culturally based inpatient and outpatient services for Native Americans as well as services targeted to women and children on reservations. Another area of concern, introduced in this domain and referred to in others as well, is the gap created by shortages in the substance abuse treatment workforce.

Discrete gaps in the design of programs also were highlighted. For example, released felons who have completed treatment successfully while incarcerated are not permitted legally to associate in their communities with other felons who were incarcerated with them. This breaks up the support groups that worked effectively for prisoners before their release. Improvements in treatment provided in correctional institutions are needed.

Attention was called to inhalant use among 11- to 13-year-olds and the lack of information about the deaths that can occur because of its effects on the heart. Statistics on inhalant use among youth were called "frightening," yet no treatment programs seem to address this substance.

The need for treatment on demand, as for patients with other chronic diseases, was mentioned by several speakers, along with the need to integrate substance abuse treatment into mainstream medicine. Acupuncture was recommended as a way to provide immediate treatment; increased funding for this method was requested.

The importance of drug-free housing following treatment also received much attention. Speakers felt that this type of housing, with strong facility management guidelines including clear policies on the eviction of residents who use substances, is a treatment intervention. It preserves the benefits of the treatment experience for people leaving treatment who do not have supportive, drug-free environments awaiting them.

Reducing Stigma and Changing Attitudes

People testifying at the public hearing concentrated their attention on what could be done to overcome stigma. CSAT representatives heard the call for its energies to be devoted to educating the public on numerous issues: (1) the importance of methadone as a legitimate medication for heroin addiction; (2) the cost effectiveness of methadone treatment compared to accepted treatments for other diseases; (3) the fact that addiction is a treatable disease; (4) the efficacy and cost effectiveness of treatment; (5) public health dangers connected with the use and abuse of alcohol and drugs; and (6) replacing myths about addiction with facts. Information should be disseminated in ways that make it readily acceptable to racial, ethnic, and cultural minority groups.

Speakers had very concrete suggestions for overcoming stigma among professionals, who could more effectively provide services for addicted persons if their attitudes toward them were different. CSAT could foster and contribute funding to provide training for members of the medical profession and develop continuing education courses for them and other professional groups. Workers in social agencies need information about working with clients who are or have been felons. Many fear them and resist providing services; this creates a problem for the substance abuse treatment field, since many of its clients who need supportive services from other agencies received treatment while imprisoned.

Similarly, education from the Federal level can help officials in Federal agencies understand the need to change attitudes toward recovering persons employed by or seeking work with Federal agencies. Attitude change is needed even in agencies providing services designed to assist people with addiction and those in recovery.

The increase in incidence of hepatitis C raised concerns because treatment is often less than optimal if the patient is thought to be addicted. The situation parallels HIV/AIDS and the associated stigma and needs an informed public to deal with what may become epidemic.

A fundamental change that speakers believed could begin within CSAT is the reformulation of terminology used to refer to addicted people. "Substance abuser" reinforces stigma, puts the blame on the individual, and actually condones drug and alcohol use that falls short of abuse. It fails to suggest that addicted people are ill and need treatment. "Drunken Indians" was another term highlighted.

Numerous speakers emphasized the importance of people in recovery acknowledging to friends and associates that they are in recovery and that treatment works. Similarly, CSAT was asked to communicate successes in treatment to the public.

CSAT can help remove stigma against treatment providers, particularly those who manage or work in methadone maintenance programs. One social worker said she "could feel other professionals move away from her" when she told them she worked in a methadone maintenance clinic.

Stigma of another sort was mentioned by a Native American speaker who described the problems faced by persons who return to the reservation after successful treatment in a dominant-culture program. Working outside the Tribal culture arouses suspicion, and nontraditional ideas such as 12-Step concepts are viewed negatively by peers.

Improving and Strengthening Treatment Systems

Integration of services was recognized by most speakers as essential to improve and strengthen treatment systems. However, to help achieve this aim, leadership was requested from CSAT in enabling treatment providers to sort out the maze of categorical funding restrictions, administrative rules, and directives from different Federal, State, and county or local agencies that make it difficult to blend service funding streams and develop integrated service strategies.

Speakers indicated that treatment programs should operate as part of multiservice centers or be able to provide "one-stop shopping" themselves. This is essential in maximizing resources, reducing duplication of services, and showing positive outcomes for clients. CSAT leadership can help them achieve this goal. Staff need training in multiple treatment approaches and in doing interagency planning.

Arguments were made for recasting addiction treatment as a chronic disease treatment system. Such a system would recognize the critical importance of housing, recovery support services, employment preparation assistance, and services that acknowledge range-of-life problems, including aging. CSAT can help establish standards and benchmarks to let programs know to what extent they are providing the full range of services that need to be part of chronic disease treatment.

Native American speakers asked CSAT to foster initiatives that recognize the isolated, rural nature of life on reservations; the mortality rate among youth that is 17 times the rate for white American youth; the relationships between addiction and suicide; and the extent of dual diagnoses among Native populations. Speakers suggested that a Federal approach to improving treatment among Native Americans should be built around consideration of these factors.

Speakers suggested that Tribal leaders in the substance abuse treatment field also need access to a robust training system from which they can learn new approaches to integrate with Native approaches to treatment. The need for new and renovated facilities in which to provide treatment is acute. One speaker suggested that, because of the high rates of addiction among Native Americans, a "disease burden" weight factor should be used when making funding decisions about grant applications from them. Another urged that CSAT work collaboratively with the Indian Health Service (IHS) to help ensure that substance abuse treatment is included in health programs it funds.

People in recovery and members of families with a recovering addict or alcoholic argued for more attention to the need for including family members in treatment; providing employment preparation as a matter of course, with practicum or real job experience during the treatment process; and establishing more social-model programs.

Service providers felt the field could be strengthened by the establishment of standard and uniform outcome measures, analogous to those of the Joint Commission on Accreditation of Healthcare Organizations. Treatment programs need computers and related technology.

Numerous speakers addressed the need to educate treatment staff about hepatitis C and prepare them to educate clients about the disease and its transmission, as well as assist in finding treatment if they have already been infected. Some argued for the need to return to a collaborative approach to treatment as opposed to a competitive marketing approach focused on profit.

Connecting Services and Research

Changing the conversation to develop a culture built on trust and collaboration among the wide variety of research and services organizations is an important precursor to bridging the gap between research and treatment. Two researchers suggested that CSAT work to change the traditional model in which a central research organization collects information from the field and disseminates findings back to the field for implementation, commenting that research also occurs in the field where practitioners accumulate experience with treatment approaches. Their experiences, or findings, need to be communicated among sites as well as with the central research organization. Methods need to be found for such communication via the Internet, conference calls, and site visits. One group encouraged CSAT to consider partnerships with higher educational institutions to train future professionals in a combination of research and treatment and prevention skills. Two speakers mentioned that policy formation should be equally connected to empirical evidence-based information.

One speaker, who noted that practitioners need research results in small increments, suggested that this can be accomplished by "stepping from one rock to the next" rather than having to wait until a huge bridge can be built. Treatment providers should have the funds and resources necessary to implement research findings; they should not be expected to carry any extra burden without some form of compensation. CSAT should find ways to reward incorporation of demonstrated best practices. A resource pool of skilled change agents should be available to review progress and provide consultation in the implementation of research findings.

One speaker asked that CSAT make funds available to States for research; States are asked to provide up-to-date statistics on trends, determine the need for public treatment, and identify treatment capacity and costs associated with closing the treatment gap, even though they have few resources to do so. States also need assistance from CSAT in funding research on medication efficacy so that treatment providers have outcomes information that they can use in making decisions regarding medications.

Two Native American representatives advocated for research targeted at finding the most effective ways, including Native treatment methods, to provide treatment to Native populations. Too often, it is assumed that the IHS or the Bureau of Indian Affairs funds research, but this has never been the case. One psychologist noted the need for research on the best processes for identifying and treating persons with alcohol-related neurological deficits. Acting-out behaviors, such as lateral violence and abuse and suicide, are common, and research is needed that will lead to the integration of culturally relevant Tribal coping and healing methods with modern Western methods of treating dual diagnosis. Tribal representatives should be included on institutional review boards. When research results are obtained, they need to be communicated with Tribal officials. Speakers noted an urgent need for information on state-of-the-art treatment methods for application within Native American communities.

Two other main concerns were raised: (1) the need for research to identify the best methods of substance abuse treatment with different minority groups, and (2) the need for national, State, and local dialog between researchers and practitioners. One speaker urged CSAT to model approaches used by NIDA in national conferences and local dialogs to inform practitioners of research results and enable them to interact directly with researchers.

Addressing Workforce Issues

Speakers emphasized, above all else, the shortage of counselors, and suggested that CSAT explore ways of marketing and attracting professionals to the treatment field either by training new counselors or supporting education for existing counselors. These steps could be accomplished with scholarships and continuing education programs. These programs could target diversity and geographic needs and secure a strong workforce by supporting increased earning power.

The particular need for counselors with the skills to serve an increasingly diverse clientele was noted. Bilingual counselors are needed. Gender inequity of counselors is another issue. Because of the low wage scale, it is difficult to attract men into counseling. One speaker noted the workers' need for a strong base of skill and knowledge that ensures treatment competency. Training should include the development of cross-system competencies among workers in substance abuse treatment and allied fields, especially with respect to hepatitis C, services to people with low incomes, and patients with disabilities.

One speaker argued that the emphasis on finding credentialed counselors and raising credentialing standards may be weakening the field, depriving it of counselors with an overarching desire to help people recover from addiction. The lack of counselors is compounded by State licensure laws that are not competency based and exclude large numbers of counselors from eligibility for reimbursement by managed care organizations. A partnership among CSAT and national organizations was urged to foster consensus among disciplines that individuals engaged in the practice of addiction treatment services must practice within the confines of a recognized discipline shaped by competency-based standards.

CSAT also was urged to work with other Federal agencies to broker relationships that address the workforce shortage; for example, the National Health Service Corps could be encouraged to fund college education for chemical dependency counselors.

F. COUNTY CENTER, TAMPA, FLORIDA, NOVEMBER 8, 1999

On November 8, 1999, in Tampa, FL, CSAT held the final public hearing, the sixth in the series. Testimony was heard regarding the five NTP domains: closing the treatment gap, reducing stigma and changing attitudes, improving and strengthening treatment systems, connecting services and research, and addressing workforce issues.

Shirley D. Coletti moderated the hearing. Serving as expert panelists were H. Westley Clark, Camille T. Barry, Kenneth A. DeCerchio, Donald Evans, Bill Janes, James R. McDonough, Neal McGarry, Stacia Murphy, Carole Otero, Thomas Scott, and Ronald Williams. Fifty-nine individuals presented testimony, some testifying under more than one domain. This report summarizes their recommendations, concerns, and comments.

Closing the Treatment Gap

Integration of treatment systems was a prominent issue. Many speakers cited the need to eliminate barriers and funding competition among different service areas with overlapping clientele. In addition, better relations and partnerships were called for between the public and private sectors. The need for quality drug testing was mentioned by numerous speakers, particularly those in the criminal justice system. Third-party payors were cited as too often dictating the course of treatment, to the detriment of clients; many speakers called for parity for substance abuse and mental health services and removing the limitations on health plan coverage of these services. Vocational training and family-based treatment were additional areas of concern. Several testifiers also spoke of the need for better transitional treatment for offender populations reentering the community. One speaker recommended legalizing marijuana so that people using it for medical reasons would not occupy treatment beds.

Other recommendations concerning specific populations included:

- *Persons with disabilities.* Establish mechanisms within SAMHSA and CSAT to identify and examine the most promising treatment models for persons with disabilities; require all SAMHSA and CSAT grantees to provide detailed plans for serving persons with disabilities within their federally funded programs; form a disability compliance workgroup to assist CSAT in formulating policy and practices in this area.
- *Individuals with dual diagnoses.* Incorporate into existing treatment programs service components that assist dually diagnosed individuals with relapse prevention, housing, child care, education, vocational rehabilitation, parenting, and health care; develop aftercare programs to help them maintain sobriety; increase current funding of services to this population; end the competition for funds among different service agencies treating this population.
- *Ex-offenders.* Legislation could help meet the needs of offenders with substance abuse problems by extending the period (typically six months) and improving the structure of intensive treatment. Intensive treatment should be followed by a transitional modality such as a halfway house to better equip offender addicts to reenter the community.
- *Elderly populations.* Allocate funds to raise the awareness of the general public and treatment professionals concerning the problem of addiction in the elderly; develop appropriate screening instruments for older adults; educate clinicians about discussing the topic of substance abuse with their older patients.

- *Adolescents.* Focus on early intervention with young people who have addiction problems and are entering the juvenile justice system for the first time; establish juvenile assessment centers to perform early intervention, identify at-risk youth, and refer them to appropriate treatment programs before they become involved at higher levels of the criminal justice system; ensure that treatment is age, gender, and culturally appropriate for the client; establish methods of effective knowledge transfer so that successful programs can be embedded in and adapted to communities; include families in both treatment and prevention programs aimed at adolescents.
- *Women.* Create programs for women to enable them to keep their children with them while they receive treatment; establish women-only groups within treatment programs.
- *Homeless populations.* Establish publicly funded substance abuse and mental health treatment in managed-care and performance outcome-based environments.
- *Clients in rural communities.* Develop long-term, inpatient treatment for drug-addicted indigent consumers in rural areas, particularly women.
- *Domestic violence offenders.* Include domestic violence offenders in targeted populations in drug courts; modify the eligibility criteria for Federal funding for drug courts to include domestic violence offenders who also have a substance abuse problem.

Reducing Stigma and Changing Attitudes

Many speakers testified to the persistent stigmatization of people with substance use disorders, particularly those with criminal records. Although attitudes have begun to change, especially with the increasing view of substance abuse as a chronic, relapsing, and remitting disease, addiction is still often seen as something that happens to others due to their own willfulness, stupidity, or lack of good sense. Although it is less shameful today to be known as a recovering alcoholic or drug addict, it is more difficult in many respects to get the help that is necessary to maintain recovery. Even when addicted people do get help, treatment is often seen as a failure — by insurance companies as well as friends and families of the addict — when they have a relapse.

Recommendations included the following:

- Providers should be educated to change their attitudes toward substance abusers. In particular, mental health professionals and substance abuse professionals should endeavor to overcome their negative attitudes about each other's clientele and procedures and learn to work together. Physicians should accept substance abuse as a disease and provide appropriate treatment and referrals.

- Health insurers should be encouraged to provide coverage for substance abuse and mental illness equal to that provided for other illnesses.
- Consumers need to organize and become more involved in education about and program development for substance abuse treatment.
- The definition of addictive illness should be broadened to include nicotine.
- Treatment providers and consumers alike should be more outspoken about the fact that treatment works and should engage in more public discussion of the commonality of the disease and options for treatment.
- A human face should be put on addiction; the anonymity associated with self-help groups contributes to attitudes of shame and stigma.
- CSAT should encourage the formation of advocacy organizations devoted to ending the stigma surrounding addictive disorders.
- Criminal offenders, even those in recovery with proven records of remaining abstinent, are denied benefits such as housing and public assistance. Exceptions should be made for public housing and educational assistance for addicts in recovery and their families, and assistance should be continued for people getting out of prison.
- The mental health and substance abuse advocacy communities should maximize their efforts by collaborating to obtain reforms in public and private treatment delivery systems, legislation, regulations, and treatment practices.
- The Federal Government should rethink its television and newspaper advertising campaign, particularly those advertisements from the Partnership for a Drug-Free America that show people throwing pottery. These advertisements inadvertently add to negative stereotypes. Instead, the Government should promote messages that treatment works and that normal people can have the disease of addiction.

Improving and Strengthening Treatment Systems

An overarching issue in strengthening treatment systems is the need for better integration and collaboration among service delivery systems. Agencies and organizations that provide services in the areas of, for example, child welfare, juvenile justice, and domestic violence still tend to work independently. Better communication through the formation of clearly defined, integrated, and supportive relationships is needed among these fields.

Education of primary care physicians was also a prominent theme. Physicians need to be educated about the disease of addiction, including the prescribing of habit-forming drugs, screening for substance abuse, and attitudes about substance abuse. An aggressive prevention intervention campaign is needed in which treatment providers work closely with physicians to educate and assist with addiction-related issues.

Specific recommendations included the following:

- Provide inducements from the Federal Government to expand local and State money in matching funds. Place emphasis on the continuum of treatment, a full-service system, skilled assessments, and structured halfway houses.
- Place greater focus on nicotine as an addictive drug and a substance of abuse.
- Allow for more capital expenditures on vehicles for transportation and the staff to operate them in rural areas.
- Mandate collaborative systems among those who affect adolescents' lives — school systems, social services, juvenile justice systems, and mental health and substance abuse treatment providers. Formalize these systems to focus on a seamless identification, referral, treatment, and reintegration of adolescents affected by mental illness, substance abuse, and other behavioral problems.
- Demand comprehensive training for those who deal with recovering adolescents, including school educators and administrators, that will not only teach about addiction, relapse, and recovery but also address cultural competence and social stigmas.
- Encourage innovative projects that force all parties in the process to reduce the difficulties experienced by adolescents reentering their schools and communities after receiving treatment. Develop teams made up of providers, school officials, social services, parents, and the faith community. Provide sufficient State incentives and funding to develop models of treatment for vulnerable adolescents, evaluate the outcomes, and determine the cost benefits of the project.

Other recommendations concerned the criminal justice system:

- Focus sanctions and sentences for low-level, nonviolent substance abusers on treatment and rehabilitation as well as deterrence and separation. Repeal mandatory sentencing laws. Judges and legislatures should craft sanctions and sentences that focus on curbing negative behavior rather than on processing offenders through the "revolving door" of treatment.
- Make access to intervention and treatment of addiction an integral part of the criminal justice system so that treatment is available in a coordinated and continuous manner at every step of the criminal justice process.

- Eliminate barriers among the various entities of the criminal justice system so that they can cooperate to reduce substance abuse.
- Include communities in planning and implementation of strategies for reducing substance abuse on a system-wide basis — leave local drug efforts to local governments, while the Federal Government restricts itself to pursuit of high-level drug dealers. State governments should focus on setting appropriate standards for treatment, corrections, and probation and parole.
- The criminal justice system should include the entire community in ensuring public safety — not only those in traditional law enforcement roles, but also teachers, clergy, business people, neighborhood activists, homeowners, and tenants — anyone with a stake in the safety of their neighborhoods and the well-being of their neighbors.
- Police should work in partnership with their communities to develop long-range strategies for reducing substance abuse and short-range alternatives to traditional responses to substance abuse and drug-related crime.

Connecting Services and Research

Improved drug testing was a focal topic under the domain of connecting services and research. There was a call to increase the number, reliability, and efficiency of drug screens. Several testifiers also pointed to the need to better identify the issues other than substance abuse that clients bring to treatment, including dual diagnosis, domestic violence, and child abuse. Clients' disabilities, such as physical handicaps, trauma, brain damage from drug use, and learning disabilities, need to be identified and studied to determine their prevalence and how they affect treatment outcome.

As in other domains, much emphasis was placed on the importance of integrating public and private treatment systems. Mechanisms are needed to secure input from consumers and community agents at all levels and to ensure outcome-driven systems. Data produced should reflect the community being served, and treatment services should be promoted across systems, including juvenile justice and nontraditional settings such as faith communities.

Other recommendations were as follows:

- Promote valid research-based initiatives at the State level as best practices.
- Fund demonstration grants that allow dollars for service delivery.
- Set aside specific and increased funding for knowledge development initiatives based on previous research.

- Increase funding for following participants over time to test the lasting effects of interventions.
- Create a national system for monitoring the provision of substance abuse treatment services to persons with disabilities.
- Fund more research on the common risk factors for mental disorders, substance abuse, and suicide and other forms of intentional violence, including homicide domestic violence, and child abuse.
- Allocate funding for research on the effects of hormone changes during and after pregnancy and their effect on relapse.
- Conduct more research on alternative therapies that utilize the mind-body connection and its usefulness in the treatment of addiction.

Addressing Workforce Issues

Discussion of workforce issues fell generally into two categories: (1) training, credentialing, licensing, and salaries of treatment providers, and (2) vocational rehabilitation and employment services provided to clients of treatment programs.

Several speakers addressed the issue of counselor salaries, many of which are perilously close to the poverty level. Along with increased salary levels, it was recommended that programs receiving block grant funds should be required to employ addictions counselors who are either licensed or certified through a State-recognized credentialing process. To determine appropriate salary levels, a national survey should be conducted of counselor salaries based on a definition of the scope of practice for various levels of clinical responsibility. Further, data should then be collected on salary levels for other, comparable positions.

Areas of the country that have shortages in addictions counselors should be identified and additional training grants should be made available to them through Single State Agencies. This effort possibly could be coupled with a salary survey.

Speakers commented that the field must do a better job of defining its practice. It is also critical to define best practices and disseminate them to the field. Addictions training should be included as part of the academic curriculum in many professional fields. Training should be academically based. A system of education, professional development, and training is badly needed. Addiction Technology Transfer Centers (ATTCs) should be required to maintain close communication and to work cooperatively with State provider associations in their regions.

Within the discussion of credentialing and licensing, there was a strong message from several speakers not to exclude the invaluable insight and experiential knowledge of non-degreed treatment providers who are in recovery. People in recovery are often exceptionally skilled in reaching difficult-to-serve clients. Their contribution must be kept in mind as competency standards are developed.

Several speakers agreed that addictions treatment should be made a specialty of medicine and that counselors should be licensed. It was argued that psychiatrists and psychologists should have to be subcredentialed if they provide or supervise treatment. Also needed is cross-training of nurses, physician assistants, family nurse practitioners, social workers, and criminal justice personnel. A statewide academy for basic training in the dynamics of addiction ought to be embedded in the curriculum for law enforcement officers. Family counselors and certified teachers also should receive training about addiction.

On the topic of vocational and job training for clients of treatment programs, it was recommended that substance abuse treatment and return-to-work and vocational rehabilitation systems work together to identify and evaluate models for providing services to individuals with substance use disorders, including those with one or more coexisting disability that negatively affects their ability to return to work. This link should be strongly encouraged by requiring vocational readiness screening for all persons served by chemical dependency treatment programs that receive Federal funding.

Other specific recommendations in this area were as follows:

- SAMHSA and CSAT should work together cooperatively with other vocationally oriented Federal programs, such as Temporary Assistance for Needy Families (TANF), the Department of Labor, and the Rehabilitation Services Administration, to support and disseminate national models for cooperative services.
- Require vocational or work-related goals on all chemical dependency treatment plans underwritten by block grant dollars.
- Fund and promote models of cooperation that demonstrate how vocational assessment, benefits analysis, and other prevocational services are incorporated into the chemical dependency treatment setting.
- Provide parity for chemical dependency treatment, as a critical mental health service, with other mental health services when provided by health maintenance organizations and other health insurance providers.
- At least some of the people in recovery serving as counselors and policymakers should share the drug culture of the clients; older recovering addicts have experiences different from those of their younger clients.

III. Written Testimony Received in Conjunction with Public Hearings

In addition to the oral testimony heard at the public hearings convened from June 30, 1999 to November 8, 1999, CSAT also accepted written testimony. Previous reports of each public hearing have summarized the testimony that was presented orally, some of which was supplemented by presenters' written testimony. This document summarizes the testimony that was submitted in written form only. Representatives of provider organizations, providers, consumers and family members, State agency representatives, and others — including two first ladies, Lura Lynn Ryan of Illinois and Hope Taft of Ohio — either submitted their written testimony at one of the hearings or sent their testimony directly to CSAT.

The following summarizes the contributors' recommendations, concerns, and other comments.

Closing the Treatment Gap

The gap in treatment resources was best quantified in the First Lady of Illinois' written testimony. She wrote that data indicate that combined State and Federal resources only provide funding to adequately address eight percent of treatment need, while studies indicate that every dollar spent for substance abuse treatment generates seven dollars in savings to society.

Testimony echoed the First Lady's remarks regarding the underfunding of treatment programs and branched into gaps in service delivery, including the need for:

- Modifications in methadone distribution and the use of methadone as a long-term treatment option.
- Reduction of treatment barriers for adults with physical, sensory, and cognitive disabilities.
- Special treatment services for older adults.
- The incorporation of family therapy and alternative treatment modalities in recovery.
- Treatment parity and other insurance reform.
- More programs for women and adolescents.
- More treatment in jails.
- Increased study on the role of substance abuse in child welfare cases.
- Education about the hepatitis C virus.

Other contributors focused on the inequities of the current system for the treatment of opiate addiction. She cited studies that have shown that persons in recovery maintaining an adequate dose of methadone will stop using heroin and often stop using cocaine. Because of disorders of the endorphin system, many recovering addicts require medication for life. The United States is one of the few industrialized countries that does not treat opiate addiction as a medical disease. Drastic changes must be made to the current clinic-based system.

Several writers concentrated their testimony on the gap between treatment needs of the disabled community and appropriate services being delivered. Americans with disabilities are at a disproportionate risk to be affected by substance abuse and are one of the least treated populations. One writer referred to a study from the State of Wisconsin that reported that only one in every 1,000 people with disabilities in need of substance abuse services actually received services. Other barriers confronting this group include treatment professionals unfamiliar with treating physically disabled individuals, disability treatment providers not being cross-trained to recognize signs of substance abuse, treatment programs that do not accommodate disabilities, and a lack of signs to communicate key addiction concepts in American Sign Language (ASL).

Advocates called for initiatives to provide grants for treatment of disabled populations that would focus on areas of treatment enhancement, materials development, and personnel training opportunities. Additionally, grant applications should require grantees to indicate the specific methods used to ensure the accessibility of their programs by disabled people, and CSAT should enforce the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973.

Providers, advocates, and consumers also discussed the treatment gap in specialty services for substance-abusing senior citizens, because 5.8 percent of persons receiving treatment are 55 or older and up to 20 percent may have a chemical dependency problem. Unfortunately, misuse and abuse of drugs and alcohol in older adults often mimic other psychiatric disorders — particularly depression, anxiety, dementia, or mania — making accurate assessment of the problem difficult even for professionals. The writers asserted that funding must be directed to senior-specific programs and to training agency staff and community workers to identify the warning signals of substance abuse in senior citizens.

A psychologist wrote about the impact of alcohol abuse on the family — it is estimated that more than 11 million children under the age of 18 are living with an alcoholic. His own one-year study demonstrated that involvement of family members in treatment increases the length of stay for female clients and the likelihood of recovery. He cited reviews of other treatment studies and outcomes that also conclude family therapy is an effective and cost-effective modality in the treatment of alcoholism.

The inequity of insurance benefits for substance abuse also was discussed. Testimony addressed a DHHS report that estimated that parity for substance abuse treatment would increase private insurance costs by only 0.2 percent.

As many as 85 percent of inmates in Department of Corrections (DOC) facilities have a substance abuse history and need treatment. A representative of the Connecticut DOC wrote about treatment programs in 18 correctional facilities in his State. Each facility conducts specific programs according to standards and program models to meet the needs of specialized populations, such as male, female, youth, and long-term inmates. Studies to evaluate the success of the programs have shown a statistically significant lower incidence of recidivism than a non-treated comparison group held at the same facilities during the same period of time. In general, the programs' benefits exceed costs by a ratio of approximately five to one (5:1).

The Child Welfare League of America (CWLA) submitted testimony regarding the significant role of substance abuse in child welfare cases. Evidence from various national studies suggests that 40 to 80 percent of all child abuse and neglect cases involve parental abuse of alcohol and other drugs. The link between familial substance abuse and entrance into the child welfare system is proving to be one of the largest and costliest public health problems in our society today. Both additional training for child welfare workers and more substance abuse treatment that involves the children of alcoholics and substance abusers are needed.

Contributors also called for additional treatment resources for women and adolescents; the incorporation of alternative treatments, such as holotropic breathwork; and attention to and public education regarding the growing HCV epidemic.

Reducing Stigma and Changing Attitudes

Providers, advocates, and consumers all agreed that a better understanding of drug and alcohol abuse by the general public would result in significant changes in attitude and would positively impact policy. One contributor wrote, "A drug war rather than an epidemic is being fought: 66 percent of all funding goes into interdiction; only 33 percent goes to prevention and treatment." She believes it would be difficult to find any other social policy so misguided or another illness so neglected.

Testimony indicated that awareness campaigns and workshops on alcoholism and substance abuse are needed, and should focus on the stigma, attitudes, myths, and facts about substance use, abuse, and addiction. The public needs to understand that addiction is a disease that requires and responds to medical treatment and that 95 percent of substance abusers are taxpayers, members of intact families, employed, and otherwise law-abiding, productive members of society.

Awareness campaigns and workshops need to be culturally and linguistically competent. In addition to the general public, the awareness campaigns also should extend to schools and businesses; students; law enforcement and correctional personnel; doctors and pharmacists; and human services professionals, family therapists, social workers, and counselors. Providing accurate, updated information is the first step to changing attitudes, judgments, and behaviors.

Friends, family members, and persons in recovery, including celebrities, should be encouraged to join or create advocacy groups to share recovery experiences and help educate, inform, and shift public attitudes.

In addition to educating the public, the contributors felt that the following would help reduce the stigma of substance abuse and change attitudes about those who abuse substances:

- Allow those going through methadone maintenance treatment to get their methadone in a professional, respectful, dignified medical setting. Allow private doctors to prescribe methadone.
- Set up systems whereby persons with substance abuse problems can be diagnosed and receive treatment as part of the welfare-to-work process.
- Provide free transportation to treatment.
- Create and distribute educational videos regarding substance abuse.
- Make more scholarships available for needed treatment positions, and require service for a set number of years following graduation.
- Address the public stigma against having treatment facilities in neighborhoods.

Improving and Strengthening Treatment Systems

More than 50 writers shared their research, ideas, and personal experiences regarding ways to improve and strengthen treatment systems. A representative of a Florida foundation advocated for the inclusion of treatment agencies, government, law enforcement, and education representatives in an effective plan to address the problem of substance abuse and promote prevention activities. She cited research that has shown the effectiveness of early and ongoing prevention education in school. Effective prevention must include training of teachers to ensure the consistency of the message.

Those providing testimony stressed the need for multifaceted and long-term program options as well as the necessity for psychological treatment interventions to be geared to, and work in conjunction with, medical and pharmacological treatment interventions. Treatment programs that take into consideration the developmental needs of the teenage consumer are a specific need. Other concepts covered in this domain included:

- Developing policy with a commitment to basic research and outcomes data collection;
- Funding innovative projects that increase family involvement in treatment;
- Integrating addictions education into all arenas of health care;
- Passing legislation that permits hospitals to detain highly intoxicated and drugged people for at least 72 hours of observation, to allow for more effective interventions;
- Making methadone treatment more readily available and ensuring adequate dosing;
- Providing more State and Federal programs for the indigent;
- Increasing the availability of integrated systems for those with co-occurring disorders; and
- Ensuring that treatment is provided by professionals and that programs applying for funds in a competitive bid process report in detail their credentials for providing required services.

Connecting Services and Research

Contributors in the domain of connecting services and research provided similar comments about the need for more attention and resources for the development and research of treatment methodologies. While funding sources seem to be demanding more research and followup of programs, one writer noted, none want to fund evaluation efforts. Another challenge is to "operationalize" research findings, to ensure that they are uniformly translated into best-practice models that then reach community treatment programs in a way that fosters implementation at the service site. Initiatives are needed that bring researchers, service providers, policymakers, and other stakeholders together to improve substance abuse treatment systems. Research results should be summarized in lay language, and clinicians need to continually update their knowledge. Newsletters, the Internet, community forums, seminars, and clinical training can be used to help integrate science-based findings into everyday practice. One contributor suggested that CSAT expand upon its Treatment Improvement Protocols (TIPs) and identify some of the most promising, replicable treatment models (e.g., dual diagnosis and cultural competency) and disseminate information about these models to States and service providers.

One writer cautioned against finding "universal cures." He stressed that treatment programs, like their clients, are unique and that this diversity should be accepted. In this regard, he felt a research tack should be adopted that uses surveying of significant numbers of subjects from diverse backgrounds, both those who have recovered and those who have not. The significant factors these people identify as critical in their recovery or recovery failures would provide important insight that could help reframe the questions to be explored by further research.

Addressing Workforce Issues

The testimony addressing workforce issues revolved around two aspects: (1) The need to attract and maintain well-trained, mature, experienced substance abuse counselors, and (2) the impact and issues of substance abuse on the workforce. All plans for improvement of the substance abuse treatment system will be to no avail if there are not enough counselors to provide services. When providers face inadequate staffing, the quality and effectiveness of services to clients decline. A representative of a Washington-based organization stated that most providers in her State have staff shortages of one to three counselors, and it typically takes three to six months to locate and hire additional staff.

Testimony suggested that to maintain highly skilled individuals in the current job market, counselors must be offered competitive salaries, but these are difficult to pay on "shoestring" budgets. Several contributors agreed that CSAT needs to explore ways to recruit professionals, particularly ethnic minorities, into the field of addictions treatment. It was suggested that this could be done by providing scholarships to new counselors entering the field and by supporting ongoing education (e.g., student loan forgiveness programs).

While some of the contributors called for ensuring proper licensure among addictions counselors, others encouraged the inclusion of more nontraditional, experienced-based personnel. One provider mentioned councils, such as the Alcohol and Drug Abuse Council (ADAC), as positive messengers to reduce the stigma of alcohol and drug abuse through education and advocacy in the workplace.

Section III: Participant Acknowledgements

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More than 150 individuals participated in the development of the National Plan to Improve Substance Abuse Treatment. In addition, over four hundred people testified at the public hearings or provided written comments. These individuals are listed here. Participation in the NTP was purely advisory in nature. Listing of a participant and their organization on this roster does not necessarily imply organizational endorsement of this report.

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DHHS Publication No. (SMA) 00-3480
NCADI Publication No. - BKD 383
Substance Abuse and Mental Health Services Administration
Printed 2000

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